PAMELA BASS COUNSELING SERVICES, PC

Please Note: This consent is **in addition** to the *Informed Consent Treatment* signed during your first session with Pamela A. Bass, MSW, LCSW, LIMHP and is not intended to be exhaustive. This is for the purpose of Telehealth Mental Health Counseling (via computer or phone). Please complete Telehealth Consent form & return to me.

Informed Consent for Telehealth Services

CLIENT NAME: ____________________________

LOCATION OF CLIENT: _______________________**DOB:** ___________

THERAPIST NAME: PAMELA A. BASS, MSW, LCSW, LIMHP **LOCATION**: Office unless otherwise noted_________________________________.

DATE CONSENT DISCUSSED: __________________

Introduction: Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, etc. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: • Patient medical records • Live two-way audio and video • Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I will be using Doxy.me or Zoom which is HIPPA compliant.

1. I understand that the video conferencing/telephone technology will not be the same as an in person session due to the fact that I will not be in the same room as my therapist.
2. I understand that I am responsible for the confidentiality in my space and for best results I should be in a quiet place with limited interruptions when I begin my session.
3. I understand the inherent potential risks to using technology including interruptions, unauthorized access and technical difficulties, I understand that my therapist or I can discontinue the Telehealth session if it is felt that the connection is not adequate for my situation or that this modality is not therapeutically beneficial for me.
4. My therapist agrees to inform me and obtain my consent if another person is present during my intake or session at any time.
5. I understand that I can direct questions about my Telehealth session at any time to Pam Bass.
6. I understand that the same confidentiality protections, limits to confidentiality, required rules for HIPAA protected information and files, and access to my files applies for Telehealth therapy.

Expected Benefits: • Improved access to medical/psychological care by enabling a client to remain in a safe environment • Continuation of therapy during COVID 19 crisis or any other crisis that prevents face to face meetings. •

Possible Risks: See #3 above

Informed Consent for Telehealth/Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my mental health therapist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical/behavioral health care.

I hereby authorize Pamela A. Bass, MSW, LCSW, LIMHP to use telemedicine in the course of my diagnosis and treatment:

____ ________________________

Signature of Client (or person authorized to sign for client) Date