Spectrum Psychology and Wellness, LLC
Boston Professional Village
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TELEMEDICINE INFORMED CONSENT FORM

I _____ [name of patient] hereby consent to engaging in telemedicine with _____ [name of provider] at Spectrum Psychology and Wellness (SPW), as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I also understand that I will be required to verify my identity before each psychological service if the telemedicine does not involve video.

I understand that I have the following rights with respect to telemedicine: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. (2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (3) I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that telemedicine services will be treated with the same privacy and confidentiality as I would be afforded in a face-to-face office setting, and that should any additional persons be present during any telemedicine services other than my provider, I will be informed of their presence and thus will have the right to request the following: (A) omit specific details of my health history that are personally sensitive to me; (B) ask additional persons to leave the telehealth session; and/or (C) terminate the session at any time. (4) I understand that there are inherent confidentiality and technological risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. (5) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. (6) I understand that I have a right to access my medical information and copies of medical records in accordance with Arizona state law. (7) I understand that any dispute arriving from telemedicine with my provider will be resolved in Arizona, and that Arizona law shall apply to all disputes.

I understand that assessing and evaluating threats and other emergencies can be more difficult when conducting telemedicine than in traditional in-person therapy. To address some of these difficulties, I understand that an emergency plan will be created before engaging in telemedicine services. I will be asked to verify the identity of the emergency contact person provided in my patient chart upon intake, who is near my location and who will be contacted in the event of a crisis or emergency to assist in addressing the situation. I understand that by listing this individual as my emergency contact, I am allowing SPW to contact them as needed during such a crisis or emergency. If the session is interrupted for any reason, such as the technological connection fails, and I am having an emergency, do not call the therapist back; instead,

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call 911, the EMPACT Crisis Hotline at 480-784-1500, or go to my nearest emergency room. Call the SPW office back at 480-621-7257 after I have called or obtained emergency services. If the session is interrupted and I am not having an emergency, disconnect from the session and SPW will wait two (2) minutes and then re-contact me via the telemedicine platform on which we agreed to conduct therapy. If I am not re-contacted within two (2) minutes, then the office will attempt to reach me by the phone number I have on file.

I have read and understand the information provided above. I understand that my emergency contact person will be contacted by SPW in the event of a crisis or emergency. I understand that SPW fee policies regarding late cancellation and no-show fees still apply to telehealth services. I have discussed it with my practitioner, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

_____ _____
Patient Signature Date

_____ _____
Custodial Parent/Legal Guardian Signature Date