WEST MICHIGAN PSYCHOLOGICAL SERVICES

259 Hoover, Suite 140
Holland, Michigan 49423
616-460-0174

CONSENT FOR TELEHEALTH CONSULTATION

West Michigan Psychological Services offers therapy in the form of video sessions ("telehealth"), but this is strictly a stopgap measure for interim sessions offered to clients who are unable to get to our office due to unforeseen circumstances. We will not provide video sessions as a sole modality for treatment.
If you are interested in using telehealth as a therapy modality, please let us know so we can discuss how it can be used. If you think video therapy sessions would be beneficial to you, please consider the following.

- The telehealth service we use with our practice adheres to the required HIPAA security standards.
- Although you may benefit from telehealth sessions, there is no guarantee that they will yield positive or intended outcomes or results similar to in-office sessions.
- There are risks and consequences to using telehealth. Sessions may be interrupted or the transmission distorted as a result of technical failures.
- Telehealth-based services may not be as complete as in-person services. Through video sessions, we may not be able to see non-verbal communication or other sensory observations that we are able to experience in person.
- Video sessions are not recorded and stored. The session is documented in a progress note just like any in-office session.
- All laws regarding the confidentiality of healthcare information and a patient's rights to his or her medical information also apply to video sessions.
- The limits of confidentiality (i.e., mandated reporting of abuse of children or vulnerable elderly, threats of self-harm or suicide, etc) also apply to video sessions.

CONSENT TO USE THE TELEHEALTH BY DOXY.ME SERVICE

Telehealth by Doxy.me is the technology service West Michigan Psychological services will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Doxy.me is NOT an emergency service and in the event of an emergency, we will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the telehealth service, neither Doxy.me nor the telehealth service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth by Doxy.me service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the telehealth by Doxy.me service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the telehealth by Doxy.me service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That use of email correspondences in order to facilitate telehealth services may or may not be HIPAA compliant.

BY INTIALLING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Initials: _____

SIGNATURES

(Must be signed in order to provide telehealth services.)

By signing this document, you are declaring your agreement with the following statement:

I have read this document and have had the opportunity to ask questions. I have discussed this with my clinician and understand the risks/limitations and benefits of video conferencing. I agree to telehealth sessions (CPT code includes the modifier 95) via video conferencing and agree to pay normally, as I would for each session utilizing my healthcare insurance.

_____ _____

Client Signature & Printed Name Date

_____ _____

If minor, Parent or Legal Guardian Signature Date

_____

Print Name(s), if minor, as well as parent/legal guardian

_____ _____

Clinician Signature & Printed Name Date