TELEHEALTH VIA VIDEO CONFERENCING AGREEMENT

After intake and the establishment of a therapeutic relationship, it may be possible for treatment delivery to occur via interactive video-conferencing (i.e., virtual "face-to-face" sessions) in lieu of, or in addition to, "in-person" sessions. Video conferencing (VC) is a real time interactive audio and visual technology that enables our clinicians to provide mental health services remotely. The VC system I use (https://vsee.com) meets HIPAA standards of encryption and privacy protection but cannot guarantee privacy. You will not have to purchase a plan or provide your name when you "join" an online meeting. Treatment delivery via VC may be a preferred method due to convenience, distance, or other circumstances. Although VC may be used when the clinician and client are in different locations, licensure regulations only allow a session to be conducted in the state in which the clinician is licensed. An occasional exception can be made if temporary permission is available from another state.

Risks may include (but are not limited to): lack of reimbursement by your insurance company, the technology dropping due to internet connections, delays due to connections or other technologies, or a breach of information that is beyond our control. Clinical risks will may include discomfort with virtual face-to-face versus in-person treatment, difficulties interpreting non-verbal communication, and importantly, limited access to immediate resources if risk of self-harm or harm to others becomes apparent. By signing the document below (page 2), you are stating that you are aware that I may contact the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911. Below, please include the names and telephone numbers of your local emergency contacts (including local physician; crisis hotline; trusted family, friend, or confidant).

Physician or Psychiatrist Name and Relationship: _____

_____ Telephone number(s): _____

Crisis Hotline and Local Crisis Centers Names: _____

Telephone number(s): _____

Family Member Name and Relationship: _____

Telephone number(s): _____

Friend Name and Relationship: _____

Telephone number(s): _____

With limited hours at 1140 Opal Court in Hagerstown.

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 of GT) via video conferencing.

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

Print Name: _____

With limited hours in Hagerstown at 1140 Opal Court