**Counseling and Psychological Services of the Upstate**

**402 Pendleton Rd. #4**

**Clemson, SC 29631**

**864-633-0210**

**Telehealth Informed Consent**

1. I agree to participate in technology-based psychotherapy and/or consultation and other health-care related information exchanges with my CAPSU clinician. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from my practitioner. It may also mean that my private health information may be transmitted from my practitioner's computer to my own or from my device to that of my practitioner via a secure link. My provider will take all precautions to ensure my communications are kept confidential.
2. I understand that there are other methods of behavioral health care that may be available to me, and I am free to choose a different provider. My behavioral health care provider has explained those alternatives to my satisfaction as well as the fact that those options may be limited in light of our current public health concerns.
3. I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information that I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy will be compromised.
4. My psychologist has explained how the telehealth sessions are performed. My psychologist has explained how telehealth services will differ from in-person services.
5. I understand that telehealth services have potential risks. For example, the technology could fail, there is a potential for unauthorized access, differences in emergency services compared to face-to-face work, or some loss of information related to nonverbal communication and not being face-to-face. I may discontinue telehealth services at any time. In that case, I understand that I can call CAPSU at (864) 633-0210 to discuss next steps with services.
6. While security protocols are in place to protect the confidentiality of client information via telehealth, I understand that in rare instances, security protocols could fail, causing a breach of privacy of personal health information.
7. I have been informed that insurance payers (e.g., Cigna, BlueCross/Blue Shield, AETNA, Tricare) may not cover services, that it is ultimately the responsibility of the client (myself) to be aware of what my provider covers. I understand that I will be responsible for costs that my provider does not cover.
8. I will provide CAPSU the names and telephone numbers of a local emergency contact and my preferred emergency services (see ‘In Case of Emergency’ Telehealth form) as part of my agreement to utilize telehealth.
9. I have read, discussed and signed the ‘Telehealth Patient Confidentiality Protocol’, the ‘Quality of Care Protocol’, and the ‘In Case of Emergency Form’ and will return these forms to Dr. Ruth before our next scheduled session.

CONSENT TO USE THE TELEHEALTH BY DOXY SERVICE

Telehealth by DOXY is the technology service CAPSU uses to conduct telehealth videoconferencing appointments. It is HIPPA compliant, simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by DOXY is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, DOXY does not provide medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth by DOXY 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 Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have this information.
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:

* I have read this agreement and agree to its term.
* I fully understand its contents including the risks and benefits of the procedure(s).
* I have been given ample opportunity to ask questions and that any questions have been

answered to my satisfaction.

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Printed Name of Client Client Date of Birth

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Signature of Client Date