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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my provider wishes me to engage in a telehealth consultation.
2. My provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO UTILIZE TELEHEALTH

Telehealth is the technology service we will use to conduct telehealth videoconferencing appointments. “Telehealth” means the use of electronic information, imaging, and communication technologies (including interactive audio, video, and data communications as well as store-and-forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education. By signing this document, I acknowledge:

1. Telehealth 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, the Telehealth Service does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Telehealth facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. 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 am agreeing to engage in Telehealth services provided by Danielle Macawile, LCSW, LCSW dba MindShift Wellness.
- 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.

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

_____	_____	_____
Client Signature	Printed Name	Date