TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ (name of patient) hereby consent to engaging in telemedicine at TranscenShift, as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Virginia/Maryland/DC/Florida but not limited to.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smartphone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact TranscenShift via phone or email to coordinate alternative methods of treatment that will be discussed during the first session. Nevertheless, if you are having trouble with internet connection, your therapist will contact you via phone call. Please ensure your counselor has your contact number if this circumstance arises. (Patient Initial: _____)

Financial Obligations: Fees associated with telemedicine appointments are payable by credit/ debit card or Zelle only. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with TranscenShift, or will send my payment via Zelle. My card will be billed the same day as my scheduled telemedicine appointment. If my card has declined, TranscenShiftwill send an invoice and payment guarantee form to update my records via email. I will promptly email the updated information back to TranscenShift so my responsibility for the session will be charged. Failure to comply will result in postponing my sessions until my outstanding balance is paid.
(Patient Initial: _____)

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. 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; expressing threats of violence towards an ascertainable victim or myself; and where I make my mental or emotional state an issue in a legal proceeding. TranscenShift's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. If you need your records sent or if your counselor needs to speak with another healthcare professional or entity then we need your written consent to do so.

(Patient Initial: _____)

Video/Audio Recording: As a general practice TranscenShift does NOT record Telemedicine sessions

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without prior written and verbal consent. (Patient Initial: _____)

I understand that I have the following rights with respect to telemedicine:

1. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. 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 counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.

2. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.

3. I understand that I will have a weekly session with my counselor, and will be prompt with my scheduled appointment time. If I am unable to make the appointment, I will notify TranscenShift. I have read and understand the information provided above. I have discussed it with my counselor, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date:_____

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