TELEMEDICINE INFORMED CONSENT

Client Name:______________________________ Date of Birth:______________

I hereby consent to engaging in telemedicine psychological services with Dr. Brinza. This may include sessions and additional communication conducted via videoconferencing, telephone, and/or e-mail as mutually agreed to by Dr. Brinza and myself.

1. I am aware that Dr. Brinza will treat all information gained through telemedicine sessions with the same high degree of confidentiality as would occur with in-person sessions. Telemedicine sessions will take place using a secure, high-speed internet connection and secure computer software (the American Telemedicine Association recommends at least 128-bit encryption to ensure compliance with HIPAA regulations). I know that I maintain responsibility for protecting my own privacy with regard to the location and computer/telephone with which I choose to receive telemedecine services. I agree to communicate through a computer that I know is secure and I will fully exit the software after my session is completed. I understand that, despite all reasonable efforts on the part of myself and Dr. Brinza, there remains the possibility that technological failures could occur or that communications could be illegally accessed or intercepted by an unauthorized party.

2. I agree that, as with all health services, it is my responsibility to confirm my health insurance benefits. This includes clarifying whether my insurance carrier provides coverage for telemedicine services and whether there are any exclusions regarding the originating site from which services take place. If my insurance policy has any exclusions, I acknowledge that I will use an approved originating site for all telemedicine services. I acknowledge that I maintain financial responsibility for any services that are not covered by my insurance carrier.

3. I understand that telemedicine services offer a variety of potential benefits (convenience, comfort, increased access to providers, etc.) but that it is not appropriate for all individuals/families. There are situations in which in-person services would be necessary, for example, in order to best read an individual's body language or to establish rapport. If I have any concerns or questions regarding whether telemedicine is right for me or my family, I agree to discuss them with Dr. Brinza and I understand that I may discontinue telemedicine services at any time. If Dr. Brinza or I determine that telemedicine is not appropriate for me or my family, I understand that I may need to be referred to a clinician in my area who can provide in-person services.

4. If I move out-of-state while I am still receiving care, I agree to inform Dr. Brinza immediately, as this may affect her ability to continue to provide me with telemedicine services depending on the laws of the state into which I move.

5. I know that Dr. Brinza makes great efforts to be available to clients by cell phone as needed. However, I understand that certain emergency situations require in-person assistance, and if such a situation were to arise, I agree to go to my local emergency room or to call 911 immediately.

I have read, understand, and agree to the information provided above. I have discussed any questions with Dr. Brinza and all questions have been answered to my satisfaction.

Signature of client or parent/guardian:____________________________ Date________________