Birchwood Counseling, LLC

Tele-Medicine/Health Consent

Client Name:_______________________________________

Consent for Telemedicine Services:

______ I hereby authorize the use of telemedicine/health services via video conferencing and or telephone platform in the course of my treatment. I understand that telehealth services involve the communication of my medical information both orally and/or visually.

_____ I understand that my telemedicine services are HIPPA compliant and will not be recorded.

_____ I have the responsibility to ensure confidentiality in my own environment such as limited the presence of others or choosing a private location.

_____ I understand that my provider and I will monitor the continued use of telemedicine to ensure that this appropriate best meets my needs.

_____ I grant my verbal/written consent to receive services via telemedicine. I understand that I may revoke my consent, not retroactively, at this time.

Technology Assessment:

_____ I have access to a privately owned device (laptop/desktop computer/smart phone/tablet) that has camera and microphone access.

_____ I have access to a fast/reliable internet connection.

Client Signature: _______________________________________ Date: _______________________