Telehealth Disclosure Statement

"Telehealth", also known as online therapy, telemedicine, or tele-mental health is a growing practice among therapists and other health providers. Using HIPAA compliant video conferencing, clinicians can meet with clients remotely for sessions. In my practice, I utilize a telehealth format both for those who prefer 100% telehealth services, as well as for those who would like to use this option from time to time when circumstances call for it.

WHAT EQUIPTMENT DO I NEED?

To participate in Telehealth appointments from your home, you will need:

- Desktop computer with a webcam, speakers, a 2.5 GHz processor, and 4 GB of RAM OR
- Laptop computer with built-in webcam and speakers, a 2.5 GHz processor, and 4 GB of RAM OR
- Tablet device with built-in webcam and speakers, OR
- Smartphone with at least iOS 11 or Android 7.0
- An internet connection that is at least 10mbps.
- For optimal results, a reliable, high-speed internet connection with a bandwidth of at least 10mbps will minimize connection issues and provide the best quality.

CONSENT TO PARTICIPATE IN TELEHEALTH

- I consent to engage in telehealth (e.g., internet or telephone-based therapy) with Stefanie Robbins, L.M.H.C., for my psychotherapy treatment.
- I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, and education using audio, video, and email communications.
- I understand that telehealth involves the communication of my medical/mental health information, both orally and visually.
- I understand that I have the right to withhold or withdraw consent for telehealth at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
- I understand that the laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)
- I understand that the dissemination to other parties or entities, of any personally identifiable images or information from the telehealth interaction, shall not occur without my written consent.

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- I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my medical information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons, the electronic storage of my medical information could be accessed by unauthorized persons, and/or misunderstandings can more easily occur.
- I understand that if my therapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service, different treatment approach), I will be referred to another provider in my area who can provide such service if possible.
- I understand that I may benefit from telehealth, but results cannot be guaranteed or assured.
- I understand that the benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
- I understand that telehealth services may not be covered by my insurance and I am responsible for all financial costs not covered by my insurance plan.

Acknowledgement Signature

Your signature below indicates that you have read this Telehealth Disclosure Statement and that you understand this agreement fully.

Client/s:

Client Name (printed) _____

Client (signature) _____ Date _____

Client Name 2 (printed, if applicable) _____

Client (signature) _____ Date _____

Parent/guardian of minor aged patients (if applicable):

Parent/Guardian Name (printed) _____ Relationship to client_____

Parent/Guardian (signature) _____ Date _____

Provider:

Stefanie Robbins, MA, LMHC (signature) _____ Date _____

Washington Licensed Mental Health Counselor, License # 60507675

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