SGW Psychological Services LLC Telehealth Consent Form

1. Telehealth

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications. I understand that my psychologist, through SGW Psychological Services LLC (hereby referred to as "Company") wishes me to engage in a Telehealth session with Company. This means that I, or a designee, will, through an interactive video connection, or via telephone means, be able to consult with a designated psychologist about my condition.

2. Identity Verification

I may be expected to provide a copy of my driver's license and other identity verifying documentation requested by the psychologist before any mental health services are provided.

3. Privacy and Security of Communications

All electronic communications between me and the psychologist will be transmitted using reasonable measures to ensure confidentiality. I will be responsible to secure and protect the functionality, integrity, and privacy of my hardware, files, and communication. Password protection for accessing my hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke I make. It is recommended that I schedule my sessions with the undersigned psychologist when and where I can ensure the greatest level of privacy for all communications. I will also be sure to fully exit all programs and hardware at the end of each session. I explicitly waive confidentiality if there is another individual at my distant site at which I am using Telehealth.

4. Risks Associated with Telehealth Services

There are privacy and security risks and consequences associated with Telehealth, despite the policies and procedures in place to guard against them. These risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of my protected health information by unauthorized persons.

By signing this information and consent form below, I acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in Telehealth and agree to waive my privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the Company to arrange a secure line of communication.

I understand that telehealth visits will not be the same as face-to-face visits because I will not be in the same room as the psychologist, and that some parts of a visit may be conducted by

individuals present with me at the direction of the psychologist. I also understand individuals may be present at either location to operate the audio/video equipment and that these individuals must maintain the confidentiality of health information disclosed, or if they join me at my discretion, then confidentiality may be waived.

I understand there are possible risks of an incomplete or ineffective telehealth visits because of the technology, and that if any of the risks occur, the telehealth visit may terminate. The risks may include:

a. Failure, interruption or disconnection of the audio/video connection;

b. A picture that is not clear enough to meet the needs of the consultation;

c. A minor risk of access to the consultation through the interactive connection by electronic tampering.

I understand that in place of this Telehealth session I may seek a future face-to-face session with the psychologist.

I understand that I will not receive any royalties or other compensation for taking part in this Telehealth session or for the authorized use of any consultation images or audio.

I release the Company, the psychologist, agents and assigns from any and all liability which may arise from Telehealth sessions, the use of interactive audio/visual connections, or from the taking or authorized use of any images or audio obtained.

There are potential risks to receiving telehealth services, including limits to confidentiality. There is a small risk for phone and video conferencing communications to be intercepted or disrupted (e.g., cut off due to lost internet connection). The Company will use only secure programs for these meetings, unless insecure programs are allowable by law and chosen by me and the Company, however there is always a risk that confidentiality of any electronic communication can be broken or compromised. This applies to email, phone, and text messages that I send every day as well; it is not new to this time or situation. While the Company and psychologist will provide services in private spaces and take all precautions to maintain the confidentiality of the phone/video conference/email/text communications with me, the Company cannot guarantee that such communications will not be intercepted.

5. Communication Interruptions

I am aware that if I am unable to connect with the telehealth platform or become disconnected during a session due to a technological breakdown, I should try to reconnect within 5 minutes. If reconnection is not possible, the Company can be reached at the following phone number: 651.493.9412.

6. E-Mail and Text Messages

The psychologist may use and respond to e-mail and text messages only to arrange or modify appointments. I understand that if I choose to e-mail or text to communicate with the psychologist, I am giving my implied consent to receive a response in the same manner. I understand that I cannot send e-mails related to my treatment via electronic communications because I understand that emails and texts are not completely secure and confidential. I also understand that any mental health-related questions or issues will not be addressed by the psychologist in any electronic communication, but will be dealt with during my next scheduled session. I further understand that any electronic transmissions of information by me or the psychologist to me are retained in my client file in my psychologist's electronic health record. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. I also know and understand that any e-mails, any communications sent through the Company website, or any other online communication platforms, are not secure and I assume the risks of the insecure transmission.

7. Audio and Video Recordings

I acknowledge and, by signing this information and consent form below, agree that neither I nor the undersigned psychologist will record via photo or video any part of my sessions unless I and the Company mutually agree in writing that the telehealth session may be recorded. I further acknowledge that Company objects to me recording any portion(s) of my sessions without the Company's written consent. I expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of my health records, and are therefore not protected by confidentiality or any other provisions under this agreement.

8. Consent to Treatment Using Telehealth and Distance Health Services

I voluntarily agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the Company to provide such care, treatment, or services as are considered necessary and advisable. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

9. Telehealth Considerations

I recognize that, if I elect to engage in video conferencing visits, I will need to use a webcam (laptop with a camera), smartphone, tablet or other electronic device with a camera during the video conferencing session. I also understand that the use of a secure internet connection is preferred.

I understand that it is important to not be in a public place (library, café) and to be in a space that is as quiet and private as possible during the session in order to protect my

privacy and confidentiality. If I do choose to be in a public place, I understand that I am engaging in an activity that is not secure and I am assuming the risk that people will may figure out that I am a therapy client at Company. I will not hold Company responsible for any breaches in confidentiality that may occur because of my public location.

If I have a legal guardian, I understand that I need the permission of my legal guardian for me to participate in video conference sessions.

10. Discontinuation of Telehealth Services

Telehealth services and care may or may not be as effective as face-to-face services. Company will continually assess the appropriateness of Telehealth for me. If Company determines that I would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to me. I may also communicate to the psychologist that Telehealth services are no longer appropriate for me. The psychologist will consider patient safety (e.g., suicidality) and health and mental health concerns (e.g. viral risk; mobility; immune function), community risk, and the psychologist's health when deciding to do Telehealth services versus in-person.

11. Verbal Consent

At times, verbal consent may or will be accepted in place of written signatures. The psychologist will review all documents with me over the phone or video conferencing services and documents will be available to view through the Secure Client Portal. Paper copies can be mailed by request. If I have given verbal consent for communication with other service providers or members of my care team, I understand that I may withdraw consent at any time.

Records in which verbal consent was obtained in lieu of written or electronic consent will include a statement such as, "Consent obtained verbally due to current health and safety concerns related to COVID-19 pandemic. Company will make efforts to obtain new forms with written signatures once we return to face-to-face service delivery."

12. Conclusion

I understand that I can revoke consent to this Agreement at any time. I also understand and acknowledge that if consent is revoked or not given, services may be interrupted.

_____ _____

Patient/Representative Signature Date

_____ _____

Relationship to Patient Witness Signature if applicable

_____ _____

Psychologist Date