Haley Weiss, MA, LPC, NCC
Haley Weiss Counseling, LLC
1315 South Allen Street, Suite 302, State College, PA 16801
Phone: (814) 826-3646 | Email: haley@hweisscounseling.com

CONSENT FOR TELEHEALTH SERVICES

1. I understand that my health care provider wishes me to engage in a telemental health consultation.
2. I understand that I will need to participate in creating an appropriate space for my telemental health sessions.
3. I understand that I will need to participate in making a plan for managing technology failures, mental health crises, and medical emergencies.
4. I understand that my counselor follows security best practices and legal standards in order to protect my health care information, but I will also need to participate in maintaining my own security and privacy.
5. My counselor has explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my counselor.
6. I understand that a telemental health consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing within the state of Pennsylvania.
7. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my mental health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
8. I understand that it is possible that receiving services by telemental health will turn out to be inappropriate for me, and that I and my counselor may have to cease work by telemental health.
9. I have had the alternatives to a telemental health consultation explained to me.
10. In an emergent consultation, I understand that the responsibility of my counselor is to advise a county crisis counselor or another appropriate authority and that my counselor's responsibility will conclude upon the termination of the video conference connection.
11. I understand that I will be billed directly in a manner that is essentially the same as a regular appointment.
12. I agree not to record video or audio sessions without my provider's consent. I understand that recordings can quickly and easily compromise my privacy, and should be done so with great care. My counselor will not record video or audio sessions without my consent.
13. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

(continued on next page)

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth video conferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my counselor and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Printed Name: ____

Signature: ____ Date: ___________________________