INFORMED CONSENT FOR THE USE OF ELECTRONIC/SOCIAL MEDIA COMMUNICATION

Telemedicine: Telemedicine is the use of electronic/internet/data transmissions to treat the needs of a client. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Examples of these include, but are not limited to: e-Mail, cell/mobile/VoIP calls, voice-mail, text messaging, Zoom/FaceTime, social media sites, and other non-face-to-face interactions and Payments (PayPal, Venmo, Credit Cards, etc).

INFORMED CONSENT

Telemedicine sessions ARE NOT TO BE RECORDED WITHOUT PRIOR CONSENT by Kim Wright, LCSW and if it is found that sessions have been recorded/shared without written consent, it is grounds for IMMEDIATE TERMINATION.

By selecting and signing below, you acknowledge that there are logistical and privacy issues that may or may not be compromised in the use of such systems. I, Kim Wright, LCSW ("clinician"), will continue to abide by the HIPAA/PHI standards you have received as part of your Initial Intake Packet.
Please read the following section to show your understanding:

(1) YOU, "the client", retain the option to withhold or withdraw consent to telemedicine at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which YOU would otherwise be entitled.

(2) The risks involved with Telemedicine include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and are open to other's intrusion.

The advantages of Telemedicine include the benefit of continuity of care in the absence of your clinician as well as the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the Telemedicine transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is MY responsibility to do the same.

(3) All existing confidentiality protections apply as noted in your HIPAA/PHI information portion of your Initial Intake Packet.

(4) All existing laws regarding client access to medical information and copies of medical records apply.

(5) Dissemination of any client identifiable images or information from the telemedicine interaction to researchers, individuals, physicians, or other persons and entities shall not occur without YOUR consent.

(6) YOU acknowledge that you have read this Consent form and have given both written and verbal consent to utilizing Telemedicine as part of your treatment.

(7) The written consent statement signed by YOU shall become part of YOUR medical record.

(8) The failure of any health care practitioner to comply with the above shall constitute unprofessional conduct.

(9) All existing laws regarding surrogate decision-making shall apply. For purposes of this section, surrogate decision-making means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(10) I will discuss with YOU any fees associated with the use of Electronic Media Communication. If there is use of Electronic Media Communication Outside of our scheduled session time, You will be responsible for Out of Pocket (not being able to use insurance) fees as determined by your therapist. Generally, anything lasting more than 15 min of Outside Session time will be charged at a rate determined by your therapist.

ACKNOWLEDGMENT OF the RISKS and BENEFITS of THE USE OF TELEMEDICINE:

I, _____, have read the above-mentioned Telemedicine Services and Informed Consent and have chosen the following method(s) of communication with Kim Wright, LCSW:

____ Zoom Sessions
____ Telephonic (cell phone usage, text messaging, voice-mail)
____ e-Mail usage/interactions
____ Internet/Social Media
____ Electronic forms of Payment (Credit Cards, Venmo/Paypal)

____ No preference
____ I do not wish to participate

____ I understand that there are both risks and benefits as mentioned within this consent form as well as others that I may not fully be aware of that can occur with or without my knowledge.

____ I understand **Sessions Are Not to be Recorded without prior Consent by Kim Wright, LCSW** and if it is found that sessions have been recorded/shared without written consent, it is grounds for **IMMEDIATE TERMINATION.**

____ I will in no way hold Kim Wright, LCSW, liable for any difficulties resulting to me or any other family member from the communication of confidential information by means of the previously mentioned means of Electronic Communication methods.

____ I will use my best effort to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information.

____ I understand that the clinician will use their best efforts to conceal personal information and abide by HIPAA/PHI standards.

____ I understand that there are no universal protocols or protective standards in the use of Telemedicine and I will hold my clinician harmless and free from liability in the event I use this method of communication and engage My clinician to receive communication in this manner.

____ I agree that I have been verbally informed in addition to this written informed consent regarding the use of Telemedicine as a means of facilitating My therapy sessions.

Client Signature and Date:

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