

Mark Travis
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CONSENT FOR TELEHEALTH CONSULTATION

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Okay to leave message: _____

Cell Phone: _____ Okay to leave message: _____

Work Phone: _____ Okay to leave message: _____

Email: _____

Preferred Communication: _____

1. I understand that my health care provider wishes me to engage in telehealth consultation or I have requested use of telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such consultation will not be the same as direct client / health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my 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.
5. 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 language in which I understand.
6. Many insurance plans now reimburse for Distance/Telehealth consultation services. I understand it is my responsibility to verify coverage for these services with my insurance

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company. I acknowledge that I am responsible for any outstanding balances owed after my insurance claims process.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE

Telehealth by Simple Practice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in when using your computer. If you wish to use your cell phone, you will need to download “**Telehealth by Simple Practice**” from the App store for IOS and Android.

By signing this document, I acknowledge:

- 1 Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911 or present to the nearest hospital emergency room for care.
- 2 Though my provider and I may be in direct, virtual contact through Telehealth Service, neither Simple Practice nor the Telehealth Service provides medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- 3 The Telehealth by Simple Practice 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 the technical information in the Telehealth by Simple Practice 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 Simple Practice 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.

Signed: _____ Date: _____

_____ Date: _____

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Client(s) Parent/Guardian Signed: _____ Date: _____

Client(s) Parent/Guardian Signed: _____ Date: _____

Therapist Mark Travis MA, M.DIV, LMFT: _____ Date: _____