**Consent to Participate in a Telehealth Appointment**

1. I understand that Amber Fry, MA, LIMHP wishes me to engage in a telemedicine consultation using Doxy.me or other HIPAA compliant telehealth service.
2. Amber Fry, MA, LIMHP has explained to me how a session facilitated by the Doxy.me or other HIPAA compliant video conferencing will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider, Amber Fry, MA, LIMHP.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me or other HIPAA compliant videoconferencing connections are not adequate for the situation.
4. I understand that if others are present during the virtual therapy visit other than Amber Fry, MA, LIMHP, they will maintain the confidentiality of the information obtained. In the unlikely event this occurrence originates from Amber Fry’s office, I understand that I will be informed of their presence in the visit and thus will have the right to request the following A) omit specific details of my history that are personally sensitive to me; B) ask the other person present to leave the room; and C) terminate the visit at any time. If others are present in the client’s environment, Amber Fry, MA, LIMHP will not be held liable if those present do not maintain your confidentiality.
5. I have had alternatives to a telehealth visit explained to me, and I am choosing to participate in a Doxy.me or other HIPAA compliant telehealth consultation.
6. I agree to provide my physical location and contact information so that in a life-threatening emergency Amber Fry, MA, LIMHP can contact local officials to provide emergency services. Should the videoconferencing software fail, Amber Fry, MA, LIMHP will contact me at the phone number provided so we can conclude our session.
7. I have had a direct conversation with Amber Fry, MA, LIMHP 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.

By signing this form, I certify:

* That I have read or had this form read/explained to me
* That I fully understand its contents including risks and benefits of the telehealth session(s)
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction
* That I have the right to withdraw permission for telehealth sessions at any time

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Client Name Date of Birth

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Client or Parent/Guardian Signature Date

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Amber Fry, MA, LIMHP Date