**A picture containing drawing

Description automatically generated**

**E. Brooke Barnard, M.S., LCMHC**

**3570 Vest Mill Road, Suite G—office**

**Winston-Salem, NC 27103**

**956 Bryansplace Road—mailing**

**Winston-Salem, NC 27104**

**336-745-1373**

**brooke@familymatterscounselingws.com**

**Consent For Telehealth Services**

1. I understand that my health care provider wishes me to engage in a telehealth session.
2. My health care provider explained to me how the video conferencing technology that will be used to have a therapy session 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 provider.
3. I understand that a telehealth session 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 session 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 with regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

**Consent to use FaceTime, Zoom, Skype, doxy.me, or Signal**

Telehealth byFaceTime, Zoom, Skype, doxy.me, or Signal are the technology services we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by FaceTime, Zoom, Skype, doxy.me, or Signal are not Emergency Services and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither FaceTime, Zoom, Skype, doxy.me, or Signal provides any medical advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by FaceTime, Zoom, Skype, doxy.me, or Signal facilitates videoconferencing and are not responsible for the delivery of any medical advice or care.
4. 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.
* 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**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT NAME (SIGNED DATE SIGNED