Heart Healing Counseling Corporation, 240 S Stadium Way, Suite 101, Tacoma, WA 98402
www.hearthealing.org 253-651-3752

Telemedicine/Telehealth Client Informed Consent

Name: _____ Date of Birth:_____

Purpose: This form is to obtain your consent to participate in telehealth sessions with Deanne Carter, LMHC (from here on referred to as "health care provider").

As an alternative to in office visits, telemedicine/telehealth sessions are available. These are live/real time interactions on a HIPPA compliant, video-conferencing platform that provides a two-way audiovisual link between a client and a health care provider. According to the WAC 182-531-1730, approved physical locations of the client at the time of the healthcare service includes "home or any location determined appropriate by the individual receiving the service".

Please initial the following acknowledging your understanding and agreement, or N/A if not applicable:

___ 1. I am responsible for verifying insurance coverage for telehealth (assuming medical necessity) on my specific plan, with Deanne Carter, LMHC license # LH60095901.

___ 2. There are *no* circumstances where there will be other personnel present, and I will inform my health care provider if others are present during my video session.

___ 3. There will be *no* audio, photo or video recordings of my telehealth session on either side.

___ 4. Telehealth with this health care provider, does *not* include email or any other electronic transmissions, besides my scheduled video session.

___ 5. Scheduling *may* be communicated via email or text with this healthcare provider.

___ 6. If I haven't made prior payment arrangements, I will make my payment via paypal: hearthealingcounseling@gmail.com prior to checking in to the waiting room.

___ 7. At the time of my appointment, I will check in to the waiting room at: **https://doxy.me/hearthealingcounseling**. Recognized by the Telebehavioral Health Institute, Doxy.me is HIPAA compliant. This link may also be found at www.hearthealing.org at the bottom of the home page, where is says "sign in to the waiting room here".
For your comfort: be in private, have your hands free, tissue nearby, silenced telephone nearby as back up, and writing material if you wish.

___ 8. My health care provider will keep written notes of sessions and store them with the same procedures as in office visits.

___ 9. All confidentiality rights and protections under federal and Washington state law apply.

___10. As with any health care service, there are risks associated with the use of telehealth, including equipment failure, poor image resolution and information security issues. *If we get disconnected and you need immediate assistance you agree to Dial 911 or your local crisis line.*
Pierce County: 1-800-576-7764, Text 741741, or National Suicide Hotline 1-800-273-8255

___ 11. Noting the above, I understand that my participation in telehealth is voluntary and I have the right to withdraw consent to telehealth at any time without affecting my right to future care.
I agree to participate in telehealth video sessions via doxy.me

_____ _____ _____

Signature Printed Name Date