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Tele-Medicine Informed Consent Form

I, _____, hereby consent to engaging in telemedicine at Phase 3 Counseling & Consultation, PLLC as part of my psychotherapy progress.

- I understand that “telemedicine” includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications.
- I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Washington State.
- I understand the potential risks of telemedicine, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear.
- I understand that it is my responsibility to ensure that my physical location during videoconferencing is private, and free from other people and interferences.
- I understand that recording of sessions is prohibited by both client and counselor.
- I understand that I will need to download ZOOM application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. Telemedicine services are provided via Regroup Connect, a HIPAA-compliant technology which receives video and audio and stores all information and information related to my treatment in a manner that is compliant with state and federal laws.
- I also understand that in case of technology failure, I may contact Phase 3 Counseling & Consultation, PLLC via phone to coordinate alternative methods of treatment.
- I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Phase 3 Counseling & Consultation, PLLC and that said company may release any information to my insurance provider required for processing my claims.

- I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Phase 3 Counseling & Consultation PLLC's cancellation policy as documented by my signature on the Informed Consent.
- I understand that telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. I agree that crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Acknowledged:

Client

Date

Phase 3 Counseling & Consultation PLLC

Date