**Lynette Pang, MA, LMHC**
**LH # 00009904**
**2366 Eastlake Ave E Suite 312**
**Seattle, WA 98102**

## 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 confidential, and generally free from other people and interferences. I understand the limitations of privacy/confidentiality and the potential risks associated with such limitations.
- To the extent possible, I agree to refrain from activities during my session which may disrupt my session. This includes activities such as eating, smoking, checking my phone/email. It is recommended that client's close out email notifications, silence their phones/devices to minimize disruption during sessions.
- I understand that recording of sessions is prohibited by both client and counselor unless otherwise discussed and agreed upon.
- I understand that I will need to download Cisco Webex 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 Cisco Webex, 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, Phase 3 Counseling & Consultation, PLLC may contact me via phone to continue the remainder of the session.
- 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:

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|---|---|
| _____ | _____ |
| Client | Date |
| _____ | _____ |
| Phase 3 Counseling & Consultation PLLC | Date |