Private Practice of Katharine Townsend, Ph.D.
Telehealth Disclosure
Telehealth Informed Consent

I hereby consent to engage in Telehealth (e.g. internet, email, telephone, or audio-video based therapy and/or communication) with Katharine Townsend, Ph.D. I understand that Telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education, using interactive audio, video, and/or data communications. I understand that Telehealth also involves the communication of my health information, both verbally and/or visually, to other health care practitioners.

I understand that I have the following rights with respect to Telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and disabled/dependent adult abuse, expressed threats of violence towards an identifiable victim, and where I make my mental or emotional state an issue in a legal proceeding. (See also Practice Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details on confidentiality and other issues.) I understand that there is no permanent video or voice recording kept of any Telehealth session. The dissemination to researchers or other entities, of any personally identifiable images or information from the Telehealth interaction shall not occur without my written consent. All existing confidentiality protections apply.
3. I understand that there are risks to using Telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychologist, that: the transmission of my health information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons, the electronic storage of my health information could be accessed by unauthorized persons, and/or misunderstandings can more easily occur, especially when communication occurs in an asynchronous manner. I understand that whenever possible, my psychologist uses HIPAA-compliant platforms to discuss my health information with me. I understand that Telehealth services and care may not yield the same results nor be as complete as face-to-face services. I understand that my psychologist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face), I will be encouraged to meet in person for appointments, or I will be referred to a provider who my psychologist believes is better suited to meet my needs. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that, despite my efforts and the efforts of my psychologist, my condition may not improve and in some cases my even get worse.
4. I understand that I may benefit from Telehealth, but results cannot be guaranteed or assured. The benefits of Telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions, transportation and travel difficulties are avoided, time constraints are minimized, and there may be a greater opportunity to prepare in advance for therapy sessions.
5. My therapist will let me know if Telehealth is covered by my insurance plan, but it is my responsibility to verify my coverage with my insurance plan, and I am responsible for fees for this service if my insurance does not cover Telehealth. I am responsible for all copayment or noncovered fees.
6. All existing laws regarding client access to mental health information and copies of mental health records apply. I understand that I have the right to access my health information and copies of my health records in accordance with Massachusetts law, and that these services may not be

covered by insurance.

I have had an opportunity to ask questions about this information, and all of my questions have been answered to my satisfaction. I understand the written information provided above.

Client signature	Date
Witness signature	Date