Adirondack Samaritan Counseling Center
A nonprofit mental health agency serving Warren, Washington, and Saratoga Counties since 1983
15 Boulevard, Hudson Falls, NY 12839 • (518) 747-2994 • Fax: (518) 747-2996

Form Consent To VideoTherapy

Patient Name: _____
Date of Birth: _____
Date Consent Reviewed: _____

For avoidance of any doubt, the terms "[CENTER]", "**we**", "**us**", or "**our**" refer to Adirondack Samaritan Counseling Center, Adirondack LCSW P.C. and the terms "you" and "yours" refer to the patient identified above.

Introduction

"VideoTherapy Services" involves the delivery of health care services[2] using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with the Center ("**Provider**") and a patient who are not in the same physical location. VideoTherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a member and a Provider;
- Interactions between a patient and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of VideoTherapy Services has represented that it incorporate industry standard network and software security protocols to protect the privacy and security of health information.

Possible Benefits of VideoTherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Possible Risks of VideoTherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.
- In the event that the video platform fails, the Provider will ask your consent to use alternate platform to complete session. Due to the Covid 19 epidemic and resulting protocols the Department of Health and Human Services is allowing providers to utilize such platforms as Apple Facetime, Facebook Messenger Video chat, Google Hangouts Video, Zoom and Skype. **These platforms will be utilized as a last resort if the secure platform is failing during session. (HHS.gov Health Information Privacy Public Health Update-Notification of Enforcement Discretion During COVID-19 Nationwide Public Health Emergency)**

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1. Please note that individual states may have additional and specific requirements for consent to video-conference based therapy including but not limited to special requirements related to the provision of mental health treatment and the confidentiality of such information. As a result, the sample provided above is intended only as a guide.

2. Consider further defining health care services ("including but not limited to") based upon the types of therapy provided by the Center.

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By accepting this Consent to VideoTherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via VideoTherapy is an evolving field and that the use of VideoTherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of VideoTherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using VideoTherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these VideoTherapy services.
7. I agree and authorize my Provider and Center to share information regarding the VideoTherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new VideoTherapy consultation with my Provider.

Patient Consent To The Use of VideoTherapy

I have read this special Consent to VideoTherapy carefully, and understand the risks and benefits of the use of VideoTherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of VideoTherapy in my medical care.

I hereby authorize Provider to use VideoTherapy in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient: _____

Witness Signature:_____

Date: _____

I have been offered a copy of this consent form (patient's initials) _____

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