SHERBONDY'S
PSYCHIATRIC SOLUTIONS

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Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Sherbondy's Psychiatric Solutions, as a part of my treatment goals. I understand that telehealth treatment may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Sherbondy's Psychiatric Solutions, that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as in person services. I understand that it will be at provider's discretion as to whether I can be seen virtually. Subject to change at any time during course of treatment.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, Doxy.me, Doximity, and Google audio/video systems are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this patient to use these systems for telehealth services. I will not hold Sherbondy's Psychiatric Solutions, or its staff liable for gathering or use of patient information by these service providers.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my provider, and all my questions regarding the above matters have been answered to my approval.

6) I must be in the State of South Carolina on the date of my Telehealth visit or I will have to reschedule my appointment.

7) I understand if I am a Telehealth patient. I will have a credit card on file to charge the morning of my appointment for payment. I understand if I cannot make my telehealth appointment, I am to notify the office 24 hours in advance to cancel or I could incur a no-show fee for that appointment. If your card was charged and your appointment was missed, we can use the credit for your next visit, account balance or we can issue you a refund at your request.

8) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

By Signing below indicates that I have read this Consent and agree to its terms.

_____ _____

Signature of client/parent/guardian Date

_____ _____

Printed name of client/parent/guardian Relationship (If applicable)