www.apexcounselingservices.com
PH: (614) 751-1090 FAX: (614) 751-1091

TELEHEALTH INFORMED CONSENT

I ____ (patient name) hereby consent to engaging in telehealth at Apex Counseling Services, LLC (ACS) as part of my psychotherapy. I understand that "telehealth" 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, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the state of Ohio.

I understand that using the Telehealth platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Technology: I understand that I am responsible for (1) having a broadband internet connection or a smart phone device with a good cellular connection (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions (3) providing the clinician my full name and date of birth to confirm my identity at the beginning of each session (4) providing the clinician the address of my location and the phone number I can be contacted at. I also understand that in case of technology failure, I may contact Apex Counseling Services, LLC via phone at 614-751-1090 to coordinate alternative methods of treatment.

Financial Obligations: I understand that I will be charged a convenience fee at start of each telehealth session. I understand that this fee is non-refundable. I understand that this charge is my responsibility and is not covered by a third-party payor. Fees associated with telemedicine appointments are payable by credit or debit card only. My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, ACS will cancel my appointment and I will be charged in accordance with the cancellation policy.

Clients using insurance: 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 Apex Counseling Services and that ACS may release any information to my insurance provider required for processing my claims.

Self-Pay clients: I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telehealth appointments in accordance with the Apex Counseling Services cancellation policy as documented by my signature.

Scheduling: I understand that scheduling is conducted through Apex Counseling Services and is based on my provider's normal clinic hours. I understand that my counselor/therapist/clinical intern has the right to terminate the session at any time if any person other than myself is also present during the session without prior permission. Telehealth appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice Apex Counseling Services *DOES NOT* record Telehealth sessions without prior permission.

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Confidentiality: 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 dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. ACS Telehealth platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the New Patient Paperwork, which I have signed.

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

1. I have the right to withdraw my consent at any time without affecting my right to future care or treatment.
2. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video/audio conferencing technology. I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I understand that at my request or the direction of my counselor/therapist/clinical intern, I may be referred to another form of psychotherapeutic services (e.g. face-to-face services) who can provide such services in my geographic area.
3. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
4. I understand that Apex Counseling Services, LLC may not provide telehealth services to me if I am outside of the State of Ohio, and I understand that I may access telehealth services from Apex Counseling Services, LLC from within the State of Ohio only.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with Ohio state law.

I have read and understand the information provided above. I understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

My signature below indicates my informed and willful consent to treatment using this platform.

____ ____________________
Print Patient Name Date

PLEASE PRINT AND SIGN IN BLUE OR BLACK INK ONLY
ELECTRONICALLY SIGNED BY:

____ ____________________
Patient or Personal Representative’s Signature Date

____
If Personal Representative, print name and describe relationship

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