Donna Brooks Non- Clinical Therapy & Coaching Services, LSW, CTP, CLC
718-701-8641

Telehealth Informed Consent

I, _____, herby consent to participate in telehealth with Donna Brooks Non- Clinical Therapy & Coaching Services, as part of my psychotherapy. I understand that telehealth is the practice of delivering health care services via technology assisted media or other electronic means between a therapist/ coach and a client who are located in two different locations.

I understand the following with respect to telehealth:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis it may be determined that telehealth services are not appropriate and a higher level of care is required.

6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 718-664-8289 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

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Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session, I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of emergency, my location is:

_____

My emergency contact person's name, address, and phone:

_____

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/ parent/ legal guardian Date

_____ _____

Signature of therapist Date

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I consent to the use or disclosure of my protected health information by Donna Brooks Non- Clinical Therapy & Coaching Services to any persons or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. I understand that further information regarding how Donna Brooks Non-Clinical Therapy & Coaching Services will use and disclose my information can be found in the Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I received Donna Brooks Non- Clinical Therapy & Coaching Services Notice of Privacy Practices currently in effect.

_____

Print Name of Individual/ Personal Representative

_____ _____

Signature of Individual/ Personal Representative Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual:

_____

Unable to obtain written consent and acknowledgment because:

- Individual refused
- Emergency treatment situation
- Individual not able to sign due to incompetence or other medical reasons
- Other:

  _____

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SUMMARY NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS A SUMMARY OF HO MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

A complete explanation of the privacy practices of Donna Brooks Non-Clinical Therapy & Coaching Services can be found in the attached Notice of Privacy Practices (the "Notice"). We are required by law to provide you with a copy of the Notice and comply with its terms. The attached Notice is meant to inform you more fully of the uses and disclosures of protected health information that we may make and your rights regarding your protected health information.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

- We will use and disclose your protected health information to provide you with medical treatment, to bill and receive payment for your medical treatment, for certain administrative purposes and to evaluate the quality of your care.
- We will make reasonable efforts to limit access to your protected health information to those persons who need access to carry out their duties.
- We may use or disclose your protected health information without your specific permission to enable third parties to perform a job for us or for other reasons permitted by law.

YOUR PRIVACY RIGHTS

- You may have the right to request certain restrictions or limitations on the protected health information we use or disclose.
- You may have the right to specify how you receive communications of protected health information.
- You may have the right to access and amend your protected health information for as long as it maintained by Donna Brooks Non-Clinical Therapy & Coaching Services.
- You may have a right to request an accounting of disclosures of protected health information made by Donna Brooks Non-Clinical Therapy & Coaching Services.

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QUESTIONS OR COMPLAINTS

If you have any questions or complaints about our privacy practices, please contact:

HIPAA Privacy Officer:

2005 Palmer Ave

Larchmont, NY 10538

PLEASE SIGN THE ATTACHED CONSENT AND ACKNOWLEDGEMENT FORM TO ENABLE Donna Brooks Non-Clinical Therapy & Coaching Services TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH Donna Brooks Non-Clinical Therapy & Coaching Services NOTICE OF PRIVACY PRACTICES.

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