Jini F. P. Tyler, LCSW
997 Commerce Drive, Suite 3F, Conyers, GA 30094
(770)268-0866; therapy@jinityler.com

Telehealth Informed Consent

I _____hereby consent to engage in telehealth (e.g., video or telephone based therapy) with Jini F. P. Tyler, LCSW. 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 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 nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my personal 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 imminent harm to oneself or others, or as part of legal proceedings where information is requested by a court of law. (See also Practice Information and Consent and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical 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 personal information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telehealth-based services and care may not yield the same results nor be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and

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the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telehealth services, 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.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

(5) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.

> Hospital #1: Piedmont Rockdale Hospital, 1412 Milstead Avenue NE, Conyers, GA 30012; (770)918-3000; piedmont.org
>
> Hospital #2: Piedmont Newton Hospital, 5126 Hospital Drive NE, Covington, GA 30014; (770)786-7053; piedmont.org
>
> Georgia Crisis and Access Line, GCAL 1-800-715-4225; mygcal.com
>
> National Suicide Prevention Lifeline, 1-800-273-8255; suicidepreventionlifeline.org

By signing this document, I understand that emergency situations 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, GCAL, the National Suicide Prevention Lifeline or go to the nearest hospital.

Signature:_____ Date:_____