JENNIFER A GARFEIN PSYD

1305 Krameria Street Suite H150 Denver 80220 • 303-344-0455 • jennifer@garfeinpsyd.com

TELEHEALTH INFORMED CONSENT

I, _____ , hereby consent to participate in telehealth with Jennifer A Garfein PsyD, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner 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 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 abuse; danger to self or others; mental/emotional health issues I introduce in a legal proceeding).

5) I understand that Dr. Garfein is licensed to practice psychology in Colorado. If I live in or are visiting another state, I understand that the law is unclear about whether Dr. Garfein's license extends to cover work done in another state. Unless I explicitly request otherwise, this form indicates my agreement that we permit Colorado's licensing board to handle any complaints I have about our work, should the need arise.

6) I understand that, for the time period when telehealth services are provided at a distance, it is important that I have a plan established to respond to emergencies that may arise since Dr. Garfein cannot be personally present to conduct an evaluation. At a minimum, this involves an agreement to consult the closest emergency room to evaluate my condition if that becomes necessary.

I have read, fully understand, and agree to abide by the policy outlined above. I have received clarification where necessary.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date