### TELEHEALTH DISCLOSURE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to engage in telepsychology (e.g., internet or telephone based therapy) with Dr. Richard Humes III as the main venue for my psychotherapy treatment. I understand that telepsychology 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 telepsychology also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

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

(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 medical information also apply to telepsychology. 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. (See also Services Contract and HIPAA Notice of Privacy Practices forms, provided during the intake/informed consent process, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telepsychology interaction to researchers or other entities shall not occur without my written consent. I agree not to record (visually, auditorily, or any other method of recording) any session or part of session without explicit written consent from the psychologist.

(3) I understand that there are risks and consequences from telepsychology. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychologist, 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 medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner. Please refer to the Informed Consent for Telepsychology provided by the psychology and available for review and download on the company website ([www.lvftc.com](http://www.lvftc.com)) for additional information regarding the risks

In addition, I understand that telepsychology based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (i.e. face-to-face service), I will be referred to a mental health professional 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 the efforts of the psychologist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telepsychology, but results cannot be guaranteed or assured. The benefits of telepsychology 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.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with the state law where I am located, that these services may not be covered by insurance, and that if there is intentional misrepresentation, therapy may be terminated.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name (If patient under age 18) (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Signature (If patient under age 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Richard Humes III, PsyD. Date