Telemedicine Informed Consent Form

I,, _____ consent to receive psychological treatment via telemedicine with Peter A. Powers, PhD, LLC to facilitate both my access to professional services and my treatment goals. I understand that telemedicine services may include evaluation, assessment, consultation, treatment planning, as well as psychological coaching and counseling. Telemedicine will occur primarily through HIPAA compliant interactive audio, video, telephone and/or other audio/visual communications. I understand I have the following rights with respect to telemedicine:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

2.The laws that protect the confidentiality of my personal information also apply to telemedicine. As such, I understand the information released by me during the course of my sessions is confidential. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to other entities shall not occur without my written consent.

3.I understand that there are risks and consequences from telemedicine including, but not limited to, the possibility, despite reasonable efforts on the part of Peter A. Powers, PhD, LLC that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that telemedicine-based psychological services may not be as comprehensive as in-person services. I understand that if my psychologist believes I would be best served by other interventions (i.e. in-person treatment), I will be referred to a psychologist or psychiatrist who can provide these services in my area.

4.By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio, video and/or computer-based psychological or psychiatric services. If I am in crisis or I am experiencing a medical or psychiatric emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.

5.By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic or manic symptoms, experiencing a life threatening or emergency situation, abusing drugs or alcohol or experiencing other concerns which may present a risk to your safety.

I have read and understand the above information and agree to participate in telemedicine services with Peter A. Powers, PhD, LLC

Client's Signature: _____

Date: _____

Client's Printed Name: _____

Client's Address (physical location during telemedicine sessions):

_____

Emergency Contact Name/Telephone Number: _____

Your Email Address (PLEASE PRINT CAREFULLY):_____