Brad K. Greenspan, MD

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Consent for Telehealth/Telephone Sessions

I attest that I am physically located in Illinois, and hereby consent to engaging in Telehealth with Dr. Brad Greenspan for the purpose of therapy treatment. Telehealth Services includes the practice of healthcare delivery; education, diagnosis, consultation, and treatment, using interactive electronic communications, often a smart phone or computer, to enable Dr. Greenspan to provide services to individuals who may otherwise not have adequate access to care. this is a relatively recent approach to delivering care and there are some limitations compared with seeing a psychiatrist in person. It is important that both the patient and the provider be located in a private place during their sessions, and that their technology provide the appropriate security protection. This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

POINTS FOR PATIENT UNDERSTANDING:

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

1. The right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
2. The laws that protect the privacy and confidentiality of client information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to other entities without my consent. 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.
3. There are risks and consequences from Telehealth, including, but not limited to, the possibility that despite reasonable efforts on the part of my psychiatrist, that: the transmission of my medical information could be disrupted or distorted by technical failures; could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. If my psychiatrist believes I would be better served by another form of psychotherapeutic service (e.g., face-to-fact services), I will be referred to a psychiatrist who can provide such service in my area.
5. None of the Telehealth sessions will be recorded or photographed without my written permission.
6. Because this is a technologically based method sometimes it may be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential
7. There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. If the video conferencing drops while I am in a session, I will have a phone line available to contact my psychiatrist and my psychiatrist or myself can discontinue the Telehealth sessions if it is felt hat the video conferencing or telephone connections are not adequate for the situation.
8. I may experience benefit from the use of Telehealth in my care, but that no results can be guaranteed or assured.
9. I will create a safety plan with my psychiatrist in case of emergency.
10. If there is an emergency during a Telehealth session, my psychiatrist will call emergency services and my emergency contacts.

I have read and understand the information provided above regarding Telehealth Services. I have discussed it with my psychiatrist, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my care. I have been advised that this chosen form of communication may not be covered by my insurance company and that I may be responsible for any fees incurred during psychotherapy which incorporates telecommunication.

INFORMED CONSENT

My signature below indicates agreement with the above terms and conditions:

Client's signature________________________________ Date____________________

Psychiatrist's signature________________________________ Date____________________