Samaritan Counseling Center

1803 Oregon Pike ● Lancaster, PA 17601 ● 717-560-9969

CONSENT TO VIDEOTHERAPY SERVICES

Client Name:_____

Date of Birth:_____ Phone Number:_____

Address:_____

City, State, Zip:_____

For avoidance of any doubt, the terms Samaritan Counseling Center, "**we**", "**us**", or "**our**" refer to Samaritan Counseling Center and the terms "you" and "yours" refer to the client identified above.

Introduction

Videotherapy services involves the delivery of health care services using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with the Center ("**Provider**") and a client who are not in the same physical location. Videotherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a member and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of Videotherapy Services has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

Possible Benefits of Videotherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Possible Risks of Videotherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements, your Provider's treatment options may be limited.

Additional Information

- You must have a webcam or a smartphone to utilize Videotherapy services.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free from distractions.
- It is important to be on time. If you need to cancel or change your Videotherapy session, you must notify the Provider at least 24 hours in advance. Late cancel/missed appointment charges may apply.
- In the event of technical problems, the Provider will contact you via phone number on file.
- Please provide the contact information for at least one emergency contact.

By accepting this Consent to Videotherapy Services, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via Videotherapy is an evolving field and that the use of Videotherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of Videotherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using Videotherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these Videotherapy Services.
7. I agree and authorize my Provider and Center to share information regarding the Videotherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new Videotherapy consultation with my Provider.

Client Consent To The Use of Videotherapy Services

I have read this special Consent to Videotherapy Services carefully, and understand the risks and benefits of the use of Videotherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Videotherapy in my medical care and authorize the Provider to use Videotherapy Services in the course of my diagnosis and treatment.

Client Name

Date of Birth of Client | Your relationship to Client (Self, Parent, Guardian, etc.). | If not Client, Print your Name

Email Address

Client signature (or parent/guardian signature if client is a minor) | Date

***Signature of minor client, if minor is 14 years or older** | Date

Email Address for minor 14 years or older (if different than email address above)

Therapist Signature* | Date

*My signature above verifies that the client received adequate explanation to make an informed decision.

Restrictions:

Verbal Authorization

The undersigned verify verbal authorization has been given. Please request client review form online for their informed consent.

Witness Signature Date | Witness Signature Date