

## TELEMEDICINE INFORMED CONSENT

This Informed Consent form is intended to inform you about **Goolsby's Clinical Services, LLC** policies and procedures regarding Telemedicine Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, have acknowledged that you understand and agree that **Goolsby's Clinical Services, LLC** will provide therapy to you according to this Telemedicine Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telemedicine Services, and agreed upon before any Telemedicine services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telemedicine and Telemental health services.

Please print a copy of this policy for your records and this policy can be available at any time if requested.

I understand that Telemedicine (also referred to as e-therapy, teletherapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemedicine. My rights to confidentiality with Telemedicine services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by me during the course of my therapy, therefore, is generally confidential, with the following exceptions:

- Mandatory reporting of child, elder, and dependent adult abuse.
- Any threats of violence I may make towards a reasonably identifiable person.
- If I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.
- If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

## GOOLSBY'S CLINICAL SERVICES, LLC

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Therapeutic treatment for mental health, both in person and through Telemedicine services, has been found to be effective in treating a wide range of clients, individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Telemedicine services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, my therapist **Kevin Goolsby, LMHC** can be contacted at **904-338-2998**. ***By signing this consent form, I am acknowledging that I know how to contact my provider in case of a disruption or emergency.***

I understand that Telemedicine treatment for mental health is different from in-person therapy. I understand that if my therapist believes I would be better served by another form of therapeutic treatment or services, such as in-person treatment, I will be provided a referral to another therapist who can provide me with recommended services, such as in person therapy.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telemedicine interaction to any other entities shall not occur without my explicit written consent. **Kevin Goolsby, LMHC** also agree to under no circumstances take any personally identifiable images from the session or store any of these images on his own devices from Telemedicine sessions.

I also understand that my Telemedicine appointment time is reserved exclusively for me. If I cannot attend my scheduled appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. If I do not provide 24 hour notice for non emergency reasons a late cancellation fee will apply. In accordance with our Informed Consent. If you are unable to attend a scheduled appointment, you will be expected to pay a **\$65.00** late cancellation fee unless you provide a 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so it will be the client responsibility to pay this fee. Similarly, if I am late to my scheduled session, I will receive my service for the remainder of my scheduled session time slot without refund.

***Also, due to certain licensing requirements the client agree to be physically in Florida each session and to give my current physical address accurately at the beginning of each session. I agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.***

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*In accordance with the American Telemedicine Association (ATA) I agree to have Telemedicine sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed at <https://www.speedtest.net/>. These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.*

*I understand that Telemedicine appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one present in the room.*

***In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.***

***I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Goolsby's Clinical Services, LLC at 904-338-2998.***

**I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.**

**My signature below indicates that I have read this Telemedicine Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemedicine Services via an online HIPAA Compliant Telemedicine Platform with the clinician listed below:**

Client Name (printed): \_\_\_\_\_  
(or parent or legal guardian)

Client signature: \_\_\_\_\_  
(or parent or legal guardian)

Clinician: \_\_\_\_\_  
Date (mm/dd/yy): \_\_\_\_\_