Cahaba Marriage & Family Counseling, LLC
1401 Providence Park Suite 250
Birmingham, AL 35242
Cahabamarriageandfamily@gmail.com
(205)440-2133

Provider: Shawne M. Sisk M.Ed., LPC, LMFT, NCC
License: AL LPC#3428 AL LMFT# 424

Telemedicine Informed Consent

I _____ hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) with Shawne. M. Sisk M.Ed., LPC, LMFT. I understand that telemedicine 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 I have the following rights with respect to telemedicine:

(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 telemedicine. 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 Office Policies and HIPAA Notice of Privacy Practices forms, provided to and signed by you in your portal or previous file, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, 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.

In addition, I understand that telemedicine 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 (e.g. face-to-face service), that form of treatment will be resumed with Shawne Sisk or another qualified provider in the area. 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 my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine 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 HIPAA and Alabama laws, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

Teletherapy Requirements Agreement:

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card or cash/check as agreed upon with my provider. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with Cahaba Marriage & Family Counseling's secure, encrypted EHR program. My card will be billed the same day as my scheduled telemedicine appointment.

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Shawne M. Sisk Cahaba Marriage & Family Counseling and that the practice may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Cahaba Marriage & Family Therapy Policies and Client Contract cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Cahaba Marriage & Family Counseling and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services.

Crisis or mental health emergencies should be directed to the local Crisis Line 205-323-7777 or by dialing 911.

Video/Audio Recording: Cahaba Marriage & Family Counseling DOES NOT record Telemedicine sessions without prior permission.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature:_____ Date:_____