Thrive Therapy Group, P. C.
42500 Hayes, Suite 500, Clinton Township, MI 48038

Informed Consent for Telehealth Treatment

1. I understand that at times video conferencing may be a viable form of treatment that my therapist and I may discuss to promote continuity of care when I cannot, actually, be present in my therapist's office due to several factors, including but not limited to: travel for work, recovering from an illness and not being able to travel, lack of access to transportation to the office, return to college, when weather advisories that make it unsafe to travel etc.

2. I understand that video conferencing is an option in which my therapist and I may use the internet on various devices, computer, tablet, phone, and will be able to see and hear each other and interact in real time to engage in therapy.

3. I understand that the policy at Thrive Therapy Group, P. C. is to use platforms like Doxy.me or Vsee (both of which are free) whenever possible. Both are encrypted to the federal standard, are HIPAA compatible and have signed a HIPAA Business Associate Agreement-attesting to HIPAA compliance. Both platforms are responsible for keeping any videoconferencing confidential and secure. Skype, FaceTime and other platforms are not as secure and there is a risk that private healthcare information may be breeched.

4. I understand that when I am engaged in telehealth therapy, it is my responsibility to choose a secure location to ensure that family, friends, employers, co-workers, strangers or hackers cannot overhear my communications or have access to the technology or devices I am using.

5. I understand that, on my end, it is my responsibility to make sure that I am using a private and encrypted WIFI, (never a public WIFI) and that my devices have protections like firewalls, anti-virus software and are password protected. I understand that my therapist is using the same standards on their devices to protect my privacy and confidentiality.

6. I understand that my therapist may only use Telehealth in states where they are licensed even though I may be in other locations. For example, if my therapist is only licensed in Michigan, they must transmit from Michigan and not from some other location they may be visiting.

7. I understand that most insurances now cover some form of telemedicine and that my therapist will have my benefits checked as a courtesy, but it is, ultimately, my responsibility to know whether or not my insurance company covers telemedicine sessions.

8. I understand there may be risks to telehealth therapy, including but not limited to: poor internet connections, technical difficulties, power failures in the middle of a session, etc.

9. I understand that if there is a loss of transmission, my therapist will call me on to complete the session. Phone sessions are not covered by insurance and there may be a private fee assessed for any part of a session that has to be completed via phone.

10. I understand that my I can discontinue telehealth therapy sessions and revoke this authorization at any time without affecting my right to future care or treatment. I also understand that my therapist has the right to discontinue telehealth sessions at any time if it becomes apparent that face-to-face treatment with the therapist would be more appropriate. I also understand that I may be referred to a therapist in my area if my therapist feels that this would be more beneficial to me.

11. I understand that I may benefit from telehealth therapy sessions, but that results cannot be guaranteed nor assured.

12. I understand that this informed consent for telehealth therapy is only in addition to my Informed Consent for Therapy and does not replace it any way.

13. By signing this form, I certify:

    - That I have read or have had this form read and/or had this form explained to me.
    - That I fully understand the risks and benefits of telehealth therapy.
    - That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Printed Name of Patient_____

Signature of Patient/Parent/Guardian/Conservator _____ Date_____