Genuine Life Psychology & Wellness, PLLC
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Jennifer S. Hartman, Ph.D.
Licensed Psychologist, Owner

Telehealth Informed Consent Addendum

I, (Full Legal Name)_______________________________________, (DOB)________________
hereby consent to engage in telehealth psychotherapy treatment (e.g., video- or telephone-based therapy) with Dr. Hartman as an adjunct for my psychotherapy treatment due to:
(check all that apply)
_____Scheduling difficulty/distance from office/frequent travel
_____Out-of-state move and transition to new therapist (time-limited)
_____Temporary relocation within Texas
_____Other addition to treatment plan

I understand that telehealth 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. Dr. Hartman uses telehealth practices to provide telehealth psychotherapy treatment.

With respect to telehealth, I understand the following considerations and offer my consent for telehealth psychotherapy treatment:

(1) I have the right to withhold or withdraw consent to the policies in this “Telehealth Informed Consent Addendum” document at any time, which would necessitate ending telehealth psychotherapy treatment with Dr. Hartman. All other agreements, consents, and policies will remain in place with Dr. Hartman until my treatment is discontinued.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth psychotherapy treatment. As such, I understand that the information disclosed by me during the course of telehealth psychotherapy treatment is covered by Dr. Hartman’s “Patient Agreement and Consent to Treatment” and “HIPAA Notice of Privacy Practices,” to which I have already consented and agreed.

(3) I understand that there are risks and consequences from telehealth psychotherapy treatment. One important consideration is related to confidentiality. Dr. Hartman endeavors to use technology that is encrypted, secure, and confidential, but all technology can be vulnerable to security risks and threats. By agreeing to engage in telehealth psychotherapy treatment, I understand and accept the risks associated with technology security threats, including, but not limited to: 1) the transmission of my medical information could be disrupted or distorted by technical failures; 2) the transmission of my medical information could be interrupted by unauthorized persons; 3) the electronic storage of my medical information could be accessed by unauthorized persons; and 4) misunderstandings can more easily occur between a patient and psychotherapist because the treatment is not in-person, especially when care is delivered in an asynchronous manner.

In addition, I understand that telehealth psychotherapy treatment may not yield the same results nor be as complete as face-to-face service. I also understand that if Dr. Hartman believes I would be better served by another form of treatment (e.g. face-to-face psychotherapy), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, as reviewed in the “Patient Agreement and Consent to Treatment.”

(4) I understand that I may benefit from telehealth psychotherapy treatment, but results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: 1) finding a greater ability to express thoughts and emotions; 2) easing transition to a new state or locale; 3) transportation and travel difficulties are lessened; 4) time constraints are minimized; and 5) there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I that these services may not be covered by insurance, and that if there is intentional misrepresentation, the therapy relationship may be terminated.

(6) I agree that ongoing telehealth psychotherapy sessions are not appropriate if I am actively suicidal, severely depressed, engaging in risky behavior, or having psychotic episodes, and will alert Dr. Hartman immediately if these conditions arise.

(7) I understand laws in another state in which I am located may limit my time/sessions with Dr. Hartman. These limitations will be addressed with Dr. Hartman.

By initialing and signing this agreement, you are indicating that you have read completely all of the documents listed below and have had all of your questions answered. You agree to the provisions and policies freely and consent to treatment with Jennifer S. Hartman, Ph.D, Genuine Life Psychology & Wellness, PLLC. Any changes must be signed by both parties. You have a right to keep a copy of this contract.

Patient Signature____________________________________ Date_________________________

Printed Name____