TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [name of patient] consent to engaging in telehealth psychotherapy with Horizon Therapy Group, LLC. I understand that “telehealth psychotherapy” includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the state of Iowa. I understand that I may 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 connection at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Horizon Therapy Group, LLC via phone to coordinate alternative methods of treatment.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only, due at time of session. I agree to have my card information on file with Horizon Therapy Group, LLC. If my card is declined, my therapist will cancel all appointments and I will be charged in accordance with the existing policy. 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 Horizon Therapy Group release of any required information to my insurance provider to process 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 Horizon Therapy Group, LLC 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 Horizon Therapy Group, LLC 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.

Video/Audio Recording: As a general practice Horizon Therapy Group, LLC DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth, as outlined in the existing Informed Consent. I acknowledge that I have read and signed this form, with the understanding of my rights. Horizon Therapy Group, LLC’s Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. I understand I have the right to withdraw my consent at any time. I understand associated risks with telehealth, including: transmission of information (despite best practice efforts), variance in quality of services/results, and changes in accessibility due to my location. I understand that Horizon Therapy Group, LLC will provide telehealth services within the state of Iowa only. I have read and understand the information provided above. I have discussed it with my therapist, and all questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

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Client’s Signature & Date Guardian’s Signature & Date Therapist’s Signature & Date