TELEHEALTH SERVICE Consent Form

Telehealth services involve the use of a HIPAA compliant telehealth platform that provides a synchronous audio/visual connection providing a two-way audiovisual link between a client and a health care provider. As a part of your services with Mark Kaplafka Counseling, LLC., there may be times where this service is discussed as a treatment option. If at any time during your treatment with Mark Kaplafka Counseling, LLC. you opt to use telehealth services, you acknowledge that:

1. My counselor explained how the use of video conferencing technology (telehealth) will not be the same as an in-person counseling session due to the fact that I will not be in the same room as my counselor.
2. I understand and agree to be in a private space where no other individuals are able to overhear the content of our session.
3. I understand that I must be present in the State of Ohio or Florida during the telehealth appointment.
4. I understand that a telehealth services have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access/data interception, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation and that I will be responsible for the fee associated with the appointment.
6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
7. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
8. The Telehealth platform chosen by your healthcare provider is not responsible for the delivery of any healthcare, medical advice or care.
9. I understand that if I choose to use to my insurance reimburse me through my out of network benefits for this service, that my provider cannot guarantee whether or not this service will be covered under my current insurance plan. As a result, I understand that it is my responsibility to verify this is a covered service with my insurance provider
10. I do not assume that my provider has access to any or all of the technical information in the Telehealth platform – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth platform.

_____ _____ _____

Client Name (please print) Signature Date