SOUTH FLORIDA COUNSELING ASSOCIATES

DR. HOVI SHROFF

TELEHEALTH INFORMED CONSENT FORM

I,_____ (Client's name) hereby consent to engage in telehealth with SOUTH FLORIDA COUNSELING ASSOCIATES as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Florida.

Due to recent COVID-19 situation, and advances in communication technology, the field of tele-therapy has evolved. It allows individuals to have access to a mental health professional by implementing electronic means to receive services. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. Without this information, tele-therapy may be slower to progress or less effective. With therapy on an online platform, the client's tone of voice, pauses and choice of words become especially important and therefore an important focus of the sessions. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress, and periodically evaluate the effectiveness of this form of therapy.

With tele-therapy, it is important to know that the therapy session will be occurring at the therapist's office or home and therefore both the client and therapist are bound by the laws of the State of Florida. In addition, clients must reside within the State of Florida, if the session is to be covered by the client's health insurance company. These laws are primarily related to confidentiality as outlined in this form and this therapist's disclosure form.

I understand that I have the following rights with respect to Telehealth:

- 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.

- The laws that protect the confidentiality of my medical information also apply to telehealth. 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. I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my written consent.

- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures. Information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services.

- 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 therapist, my condition may not be improve, and in some cases, may even get worse.

- I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

- I understand that, if I am in need of emergency mental health services, I may contact 911 or my local emergency room.

I have read and understand the information provided above. I have discussed it with my therapist, and my questions have been answered to my satisfaction.

Signature of client/parent/guardian. If signed by other than client, indicate relationship.

Print Name:_____ Date:_____

Client's Signature or Personal Representative's Signature:_____

(By typing my name on this line, I acknowledge that this acts as my electronic signature and agreement to the above-mentioned terms).