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TELEHEALTH INFORMED CONSENT

Patient Name: _____Date of Birth: _____

PURPOSE & DESCRIPTION

Telehealth (tele-mental health) is the delivery of psychotherapy or consultation services using secure, technology-assisted media (e.g., HIPAA-compliant video platforms, telephone) between a provider and a client in two different locations. Barbara Winter PhD PA utilizes the HIPAA-compliant version of Zoom.

BENEFITS

- Increased access to services for clients who are unable to attend in person.
- Continuity of care during travel, relocation, or other disruptions.
- Convenience due to reduced travel time.
- Research suggests that telehealth can be as effective as in-person therapy for many concerns.

RISKS & LIMITATIONS

- Technical failures or interruptions in transmission.
- Potential breaches of confidentiality by unauthorized persons.
- Limited ability to observe non-verbal cues.
- Telehealth may not be appropriate in cases of active crisis, suicidal or homicidal intent, or severe psychiatric symptoms requiring a higher level of care.

CONFIDENTIALITY & PRIVACY

- No sessions will be recorded by either party.
- Privacy laws protecting your Protected Health Information (PHI) apply to telehealth, except where disclosure is permitted or required by law (e.g., danger to self/others, suspected abuse).
- You are responsible for using a private location and secure internet connection.

LOCATION & JURISDICTION

You must be physically located in Florida, New York, or a PSYPACT-participating state at the time of each session. You agree to provide your exact location at the start of each telehealth appointment.

EMERGENCY PROTOCOL

At the start of each session, in case of an emergency, you will provide:
your exact physical location, a contact person who will only be contacted to go to your location or take you to the emergency room or a hospital in the event of an emergency. If a session is disrupted and cannot be reconnected within 10 minutes, please call 561-995-4004.

CONSENT

I understand the nature, benefits, and limitations of telehealth, including the risks described above. I also understand that the agreements I signed when we started working together (HIPAA, Patient Services Agreement) still apply. I understand I may revoke this consent in writing at any time. I consent to receive psychological services via telehealth from Barbara Winter PhD PA.

Signature: _____Date: _____

Parent/Guardian Signature (if applicable): _____Date: _____

Updated August 9, 2025