

# Pacific Bay Integrative Health Center

## Informed Consent to Use Telehealth

Unforeseen circumstances (e.g., illness, weather related events, academic breaks during the school year, etc.) may prevent personnel at Pacific Bay Integrative Health Center (PBIHC) to deliver services via regularly scheduled face-to-face visits. To minimize disruptions to care, telehealth psychotherapy services will be utilized for a *limited period of time* via a HIPAA-compliant electronic communication platform or via telephone. Procedures to safeguard patients' Protected Health Information already in place at the PBIHC will be extended to psychotherapy services provided via telehealth.

### Consent and Terms of the Plan

I, Type your name here. have read the above statement and consent to receiving psychotherapy services via (initial below to indicate consent):

Initial Here. PBIHC uses Zoom, which is an internet browser-based telehealth system. Zoom is HIPAA-compliant and provides both audio and video.

Because telehealth is different than face-to-face care, there are some policies that you should be aware of in order to telehealth to work most effectively. Please initial next to each of the following statements if you understand and agree to making telehealth work for your therapy:

Initial Here. My therapist and I will schedule sessions per usual. This means that I will log on to Zoom a few minutes before our session so that we can start the session on time. A backup number to reach me at is Type your phone number

Initial Here. I understand that it is my responsibility to be in a quiet and private room to protect my own privacy. PBIHC and my therapist cannot be responsible for privacy on my end of the communication.

Initial Here. I will be using either a computer with a webcam or a smartphone to access telehealth services **AND** will be using a secure internet connection (**not** a public WiFi network) to maximize my privacy. PBIHC cannot be responsible for the security of your internet connection.

Initial Here. I understand that it is important that I minimize distractions on my own computer so that I can fully attend to our sessions. That means I will turn off notifications, close internet tabs, close out games and applications, and not check email or other messages during my session.

Initial Here. There are laws and regulations that can sometimes limit if a therapist can practice telehealth (i.e., across state lines). Similarly, in the event of an emergency, where I am located can affect my options for care and support. I agree to provide my location when asked so that my therapist and I can respond appropriately in the event of an emergency.

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Type Your Name Here

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Name (Consenting Parent if Patient is Under 18 Years of Age)

Type the Name of Your Child if You Are Consenting for Them

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Name of Child

Click to Enter the Date that You Are Consenting

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Date of e-Signature

Type Your Name Here

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Therapist

To Be Entered by Therapist Only

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Date that Therapist Witnessed Signature