Peninsula Pastoral Counseling Center
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CONSENT TO VIDEOTHERAPY

CLIENT NAME: _____
LOCATION OF CLIENT : _____

DATE OF BIRTH: _____

CLINICAL RECORD #:_____

TREATING PROVIDER: _____ LOCATION: _____

DATE CONSENT DISCUSSED: _____

For avoidance of any doubt, the terms "**CENTER**", "**we**", "**us**", or "**our**" refer to **Peninsula Pastoral Counseling Center ("PPCC")** and the terms "you" and "yours" refer to the client identified above.

Introduction

"**VideoTherapy Services**" involves the delivery of psychotherapy using electronic communications, information technology or other means between a mental health care provider employed by the Center ("**Provider**") and a client who are not in the same physical location. VideoTherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a member and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

PPCC uses Zoom Video Communications, Inc. ("Zoom") in its provision of VideoTherapy Services. Zoom has represented that it incorporates industry-standard network and software security protocols to protect the privacy and security of health information.

Possible Benefits of VideoTherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Possible Risks of VideoTherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not be able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.

By accepting this Consent to VideoTherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of psychotherapy via VideoTherapy is an evolving field and that the use of VideoTherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of VideoTherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using VideoTherapy, and that I may need to seek clinical care and treatment in person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these VideoTherapy services.
7. I agree and authorize my Provider and Center to share information regarding the VideoTherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new VideoTherapy consultation with my Provider.
9. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where permitted by law.
10. I understand that my Provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Patient Consent To The Use of VideoTherapy

I have read this special Consent to VideoTherapy carefully, and understand the risks and benefits of the use of VideoTherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of VideoTherapy in my medical care.

I hereby authorize Provider to use VideoTherapy in the course of my diagnosis and treatment.

Signature of Client (or person authorized to sign for patient): _____

Date: _____

If authorized signer, relationship to patient: _____

I have been offered a copy of this consent form (client's initials) _____