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(518) 588-7156 phone  
(518) 309-7838 fax

### TELEHEALTH CONSENT FORM

**Telemedicine/Telehealth.** You have elected to engage in telemedicine with Dr. Holly Serrao, PhD as part or all of your treatment. You understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. You understand that you have the following rights with respect to telemedicine:

1. You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
2. The laws that protect the confidentiality of your medical information also apply to telemedicine. Certain mandatory and permissive exceptions to confidentiality, such as those listed above, also apply to telemedicine. You understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your written consent.
3. You understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of your psychotherapist, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your medical information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons. In addition, you understand that telemedicine based services and care may not be as complete as face-to-face services. You also understand that if your psychotherapist believes you would be better served by another form of psychotherapeutic services (e.g. face-to-face services) you will be referred to a psychotherapist or mental health agency who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, despite your efforts and the efforts of your psychotherapist.
4. You understand that you may benefit from telemedicine, but results cannot be guaranteed or assured.
5. You understand that you are responsible to pay in full for any sessions that your insurance refuses to cover, and your cost will be based on Dr. Serrao's fee schedule if she is not in network with your insurance company.
6. You accept that telemedicine does not provide emergency services. Dr. Serrao will discuss an emergency response plan with you.
7. You understand that you are responsible for (a) providing the necessary computer, telecommunications equipment and internet access for telemedicine sessions, (b) the information security on your computer and related devices, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for your telemedicine sessions.
8. You understand that you may use email to communicate with Dr. Serrao about scheduling and other logistics, but confidentiality of emails cannot be guaranteed. Dr. Serrao discourages clients from disclosing confidential or sensitive information by these methods.
9. You understand that you have a right to access your medical information and copies of medical records in accordance with New York law.

**Acknowledgement. By signing below, you acknowledge that:**

1. You have reviewed and fully understand the terms and conditions of this Agreement, and have been given access to this document to review if you desire. You have discussed such terms and conditions with Dr. Serrao, and have had any questions with regard to its terms and conditions answered to your satisfaction. You agree to abide by the terms and conditions of this Agreement, and you consent to participate in psychotherapy with Dr. Serrao.
2. You have been informed of Dr. Serrao's Privacy Practices
3. You authorize the release of any medical or other information necessary to process insurance claims.
4. You are financially responsible to for all charges, including unpaid charges by your insurance company or any other third-party payor.

Patient Name: \_\_\_\_\_

Patient Signature & Date: \_\_\_\_\_