

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than an in-person visit. In telehealth services, mental health information is used for consultation, assessment, diagnosis, treatment, follow-up, and education. Health information is exchanged interactively through electronic communications. Telephone consultation, videoconferencing, e-health technologies and remote patient/client monitoring are all considered telehealth services. Please review and initial all sections below, sign the form, then bring it to our first session, mail it to Dr. Gulbe Walsh, P.O. Box 732, Ben Lomond, CA 95005 or email it to Susan@WillowpondWellness.com

_____ 1. I understand that telehealth involves the communication of my health and mental health information in an electronic or technology-assisted format.

_____ 2. I understand that I may opt out of a telehealth visit at any time. This will not change my ability to receive future care with Willowpond Wellness Psychological Services.

_____ 3. I understand that telehealth services can only be provided to patients/clients, including myself, who are residing in the state of California at the time of this service.

_____ 4. I understand that telehealth fees are due and billing information is collected in the same manner as an in-person session.

_____ 5. I understand that all electronic health communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:

a. It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
b. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
c. Despite reasonable efforts on the part of Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services, the transmission of health and mental health information could be disrupted or distorted by technical failures.

_____ 6. I agree that information exchanged during my telehealth visit will be maintained by Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services.

_____ 7. I understand that health information, including behavioral and mental health records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own mental health records or a summary of these records if more appropriate for my care.

_____ 8. While Dr. Susan Gulbe Walsh does not electronically record conversations or sessions, I understand that Zoom may not provide a completely secure HIPAA-compliant platform, due to possible technological failure or breach issues, but I willingly and knowingly wish to proceed.

_____ 9. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others, which includes my agreement not to electronically record sessions and conversations unless mutually agreed upon with Dr. Susan J. Gulbe Walsh.

_____10. Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____11. I agree that I have verified to Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services my identity and current location in connection with telehealth services. I acknowledge that failure to comply with these procedures may terminate any telehealth visit.

_____12. I understand that I have a responsibility to verify the identity and credentials of Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services, who is providing my care via telehealth, and to confirm they are my mental healthcare provider.

_____13. I understand that electronic communication should never be used for emergencies, urgent requests, or time-sensitive matters.

_____14. I understand that electronic communication may be used to communicate highly sensitive health and mental health information, such as treatment for or information related to alcohol or other drug use and/or dependence.

_____15. I understand that Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services may choose to forward my information to an authorized third party, with or without my permission, depending on emergency or other legally binding circumstances. Therefore, I have informed Dr. Gulbe Walsh of any specific information I do not wish/would prefer not to be transmitted through electronic communications.

_____16. I understand the inherent risks of errors or deficiencies in the electronic transmission of health and mental health information during a telehealth visit.

_____17. I understand there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when behavioral health and mental health care is provided.

_____18. To the extent permitted by law, I agree to waive and release Susan J. Gulbe Walsh, Ph.D. at Willowpond Wellness Psychological Services from any claims I may have about telehealth visits.

By signing below, I certify that I have read and understand this agreement with the opportunity to have questions answered to my satisfaction.

Patient/Client Signature	Date	Printed Name

I certify that I have explained the nature of this agreement to the patient/client and have answered all questions. I believe the patient/client understands this form and what I have explained.

Susan J. Gulbe Walsh, Ph.D. Signature	Date	Printed Name