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Beacon Psychology Services, LLC

"Lighting the path to full potential"

www.BeaconIndiana.com

Telehealth Informed Consent Form

I, _____, hereby give my consent to engage in telehealth with Beacon Psychology Services LLC ("BPS") as part of my psychological treatment. I understand that "telehealth" includes the practice of psychological services such as diagnosis, consultation, and treatment using interactive audio and video communications, particularly the use of programs including but not limited to Facetime and Doxy.Me. I understand and agree to the following:

- Telehealth is not a replacement for traditional face-to-face treatment with a BPS provider and shall be used as a temporary method of service delivery.
- All applicable Indiana laws and HIPAA laws that protect confidentiality and privacy of my medical information shall also apply to my involvement with telehealth.
- I understand that all telehealth carries a risk that my medical information could be interrupted, distorted, and/or accessed by an unauthorized person/party.
- I understand that telehealth programs such as Skype and Doxy.Me provide strong encryption yet may not meet full HIPAA requirements, and my privacy needs are met in a manner consistent with my cellular phone service and the US Postal Service.
- I understand that telehealth generates from my home state of Indiana, and that telehealth services are billed in Indiana.
- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment at BPS.

I have read and understand the information provided above, and I have discussed any concerns or questions with my BPS provider. My signature below represents my understanding of the risks and benefits related to the use of telehealth as part of my psychological treatment at BPS.

_____ _____

Patient Signature Date signed

_____

Witness