

Michelle Samuel, LLP, LCSW, ACSW

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<http://www.effectivepsychotherapy.net>

Informed consent for participation in Telemedicine

I, _____, hereby consent to participate in telemedicine with Michelle Samuel, LCSW., as part of my psychotherapy. I understand that telemedicine is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemedicine:

Telemedicine has advantages as far as accessibility and convenience, but it has some drawbacks. Telemedicine sessions have limitations compared to in person sessions, among those being the lack of personal face to face interactions, the lack of visual and audio cues in the therapy process. Traditional face to face meetings are preferred whenever possible.

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks, benefits, and consequences associated with telemedicine, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) 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 the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemedicine unless an exception to confidentiality applies (i.e. mandatory

reporting of child, elder, or vulnerable adult abuse; danger to self or others;).all rules and regulations which apply to the practice of therapy in the state of Michigan also apply to Telemedicine.

5)I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemedicine services are not appropriate and a higher level of care may be required.

6)I understand that during a telemedicine session, we could encounter technical difficulties resulting in service interruptions. If this occurs,, please call me at 734-926-9169 and we will discuss alternative methods to continue the session.

7. I understand that I must be a resident of the state of Michigan, and that I must be physically present in the state of Michigan during my appointments with Michelle Samuel LCSW to be eligible for Telemedicine services from Michelle Samuel LCSW, except during the period of Covid-19, or if you discussed your situation with me, as certain states allow telemedicine from other states..

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with Michelle Samuel LCSW, and all of my questions have been answered to my satisfaction. . I hereby give my informed consent for the use of Telemedicine in my care.

Name of patient _____

Signature of Patient: _____

Date: _____

Witness: _____ Date _____