Megan Bisbee, LCMHC
Licensed Clinical Mental Health Counselor
(VT #068.0134164)
Full Circle Health and Wellness, LLC

15 East State St.
Montpelier, VT 05602
Ph. 802-505-1748
drwhitefullcircle@yahoo.com
www.fullcirclehealth-wellness.com

Telehealth Informed Consent

I_____ hereby consent to engage in telehealth with Megan Bisbee, LCMHC. as part of my mental health care. I understand that "telehealth" includes the practice of mental health care delivery, diagnosis, assessment, consultation and treatment using live interactive audio-video software. Full Circle Health and Wellness uses Doxy.me, which is HIPAA compliant. Telehealth serves to more broadly meet the needs of the community by not requiring in person face-to-face sessions. Both the client and the therapist will be in the state of Vermont when these services are provided.

I understand that I have the following rights with respect to telehealth:

1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2) The laws that protects the confidentiality of my medical records also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder and dependent adult abuse; expressed threats of violence to an identified victim, risk of harm to oneself; and when required by a court of law. I understand that the dissemination of any personally identifiable images or information from telehealth interaction to another entity or person shall not occur without my written consent.
3) I understand there are risks and consequences related to Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of therapist, that: there could be disruptions related to technical difficulties or failures; and/or the potential for your private healthcare information being accessed by an unauthorized individual. Steps have been taken to protect your private information and confidentiality including the use of HIPAA compliant software.
4) I understand my records will continue to be stored in a locked cabinet only accessible to my therapist or me upon request as federal and state law requires.
5) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
6) Should there be a crisis, I understand I am to still to utilize Washington County Mental Health Screeners, 911 or my local hospital.
7) Telehealth does not mean that your therapist will be available to you at times outside of planned therapy sessions.

8) In the event that there is an unexpected disruption to a telehealth session, I give Megan Bisbee, LCMHC permission to contact me via these means. I understand that insurance will not cover sessions that do not use live audio-visual software.

_____Phone provide number:_____

_____Text provide number:_____

_____email Provide email:_____

9) I understand that Megan Bisbee reserves the right to deny telehealth services if, in her clinical opinion, it is not an appropriate means of health care delivery for my particular circumstances, clinical presentation or safety.

_____ _____

Signature of Client/Parent/Guardian/Conservator Indicate relationship if not client

_____ _____

Date Megan Bisbee, LCMHC