ClearPath Psychiatry & Counseling

Telehealth Consent

I consent to engage in telehealth (video/audio) services with ClearPath Psychiatry & Counseling.

1. Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth. I agree to be in a private, secure, and quiet space during my sessions to ensure my own privacy.

2. Technology: I understand that telehealth involves the use of technology, which can occasionally experience technical difficulties, interruptions, or failures. If a connection drops, the provider will attempt to call my provided phone number.

3. Location: I understand I must be physically located within the state my provider is licensed to practice in during the session. I must inform my provider of my exact physical location at the start of each session for emergency response purposes.

Patient/Guardian Signature: _____ Date: _____