Daniel Legerski, Psy.D., L.P., LLC

Emergency Telehealth Implementation Consent

Client:_____ Phone Number:_____

Address: _____

Email: _____

Out of an abundance of caution in response to COVID-19 and the national and state declarations of emergency, my practice will be moving to video-based services (i.e., telehealth) using Doxy.me or telephone sessions to help control community spread of the virus. Doxy.me is a HIPAA-compliant telehealth platform using 128-bit encryption. This is a user-friendly platform that you can use on your laptop, cell phone, or iPad. You essentially just click on the link I send you (https://doxy.me/drdaniellegerski), check in, and I will "come get you from the waiting room" as usual at the appointed time. You DO NOT have to set up a Doxy.me account. Supported web browsers are Google Chrome and Firefox.

Participating in Telehealth services requires that you (the client) agree to the following:

1. I will provide my own technology (including a secure internet connection, video/webcam, microphone and audio). A smart phone will work, but it is less ideal and less secure.
2. I agree to originate my appointment from a non-public location that allows privacy and minimizes the ability of the appointment being overheard. I agree to not initiate my telehealth appointment in a public place, while driving a car, using public transportation, or being a passenger in a car.
3. I agree to participate in telehealth services dressed appropriately, as if I was attending in-person appointments.
4. If I do not uphold the expectation of providing a safe and confidential space, the appointment will be ended, and I will be responsible for fees associated with appointment cancellation.

Consent for Telehealth Services

1. My provider has explained that receiving services using video conferencing may not be as complete as traditional face-to-face services.
2. I understand that telehealth services have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
3. I understand that there are potential risks to telehealth including interruptions, unauthorized access, and technical difficulties.

4. I understand that if there is a service disruption due to technology failure, that my provider will call me by telephone at the number provided above to continue the appointment in this format or discuss other options for the appointment.
5. I understand that the provider or I can request to discontinue the telehealth services if it is agreed that the video conferencing connections are not adequate for this situation. Charges will be adjusted accordingly.
6. I understand and accept that telehealth does not provide emergency services. If I am experiencing an emergency situation, I understand that the protocol would be to call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I may also call the National Suicide Prevention Lifeline at 1- 800-273-TALK (8255) or contact the Crisis Text Line by texting MN to 741741 for free 24 hour hotline or crisis text support.

Fees
The same fees, including copays and deductibles, will apply for telehealth as they do for in-person psychotherapy. During this time of crisis, many insurance companies are lifting any restrictions on telehealth. **Nevertheless, please contact your insurance company prior to our engaging in telehealth sessions in order to determine whether these sessions will be covered.** If your insurance provider does not cover electronic psychotherapy sessions, you will be responsible for the charges.

Records
The telehealth sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent
This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to telehealth communications by providing written notification to Daniel Legerski, Psy.D., LP. Continued use of telehealth services will be reevaluated at the conclusion of the COVID-19 national and state emergencies.

My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____
Client Date

_____ _____
Therapist Date