INFORMED CONSENT: ADDENDUM FOR TELEHEALTH SERVICES

Dr. Messina & Associates, Inc.
(817) 818-6445
www.drmessina.com
info@drmessina.com

This form is an addendum to the "Informed Consent, Office Policies, & General Information Agreement for Psychological Services."

I consent to engage in telehealth services (e.g., internet or telephone-based therapy or consultation) with Dr. Messina & Associates, Inc. as the main or supplemental venue for my and/or my child's psychotherapy treatment or consultation service. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications.

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 and/or my child's right to future care or treatment.

2. The laws that protect the confidentiality of my and/or my child's medical information also apply to telehealth. As such, I understand that the information disclosed by me and/or my child during the course of therapy or consultation is generally confidential, however, there are exceptions to confidentiality (see "Informed Consent, Office Policies, & General Information Agreement for Psychological Services" for more information).

3. I understand that I will need access to a smartphone, tablet, or computer with internet access, and that utilizing a secure internet connection rather than public/free Wi-Fi is recommended.

4. I understand that I and/or my child may benefit from telehealth services, but results cannot be guaranteed. Some benefits of telehealth may include obtaining therapeutic services from the comfort of my home, and minimizing travel difficulties and time constraints. Telehealth services may or may not be reimbursed by health insurance companies. Rates for telehealth services are the same as in-person services, and are discussed in detail, along with the cancellation policy and other details in the "Informed Consent, Office Policies, & General Information Agreement for Psychological Services" form.

5. I understand that there are risks from telehealth services, such as the possibility that the transmission or storage of my and/or my child's medical information could be disrupted or distorted by technical failures, or interrupted or accessed by unauthorized persons. I also understand that telehealth services may not yield the same results, nor be as complete as face-to-face service. Telehealth services may bring up additional complexities and potential disadvantages to the therapeutic process. For example, your therapist may have more difficulty detecting nonverbal cues, tone, or affect, which could affect diagnosis and treatment. Acute crises and severe psychological problems may not be effectively handled exclusively via telehealth. If a crisis or emergency situation occurs, I agree to call 911 or go directly to an emergency room. Your therapist may also call 911 or other support services to request assistance and/or dispatch to your location. An emergency contact and nearest emergency department should be provided to your therapist when receiving telehealth services. If your therapist assesses, at any point, that telehealth services are not appropriate, alternate treatment options will be discussed with you and/or appropriate referrals will be provided.

6. The Texas Board of Psychology requires the following statement and information to be provided in writing when rendering telehealth services: "Be it known that the Texas State Board of Examiners of Psychologists

Initial:_____

receives questions and complaints regarding the practice of psychology. For assistance please contact: Texas State Board of Examiners of Psychologists, 333 Guadalupe, Suite 2-450, Austin, Texas 78701, (512) 305-7700, or 800-821-3205." Dr. Messina's license number is 36673. Licenses can be verified on the Board's website at https://www.tsbep.texas.gov/

Emergency Contact Name _____ Phone Number _____

Nearest Emergency Room (Name of Hospital) _____ City _____

I have read, understand, and agree to this Informed Consent: Addendum for Telehealth Services.

Patient Name (Print) _____

Signature (unless minor) _____ Date _____

Parent/Legal Guardian Name (Print) _____ Parent/Legal Guardian Name (Print) _____

Signature _____ Date _____ Signature _____ Date _____

Initial:_____