
# Partners in Family Wellness, PLLC

## Telehealth Electronic Informed Consent

This electronic informed consent is for the specific purpose of providing telehealth services via Doxy.me a HIPPA-compliant telehealth platform. Doxy.me services may include provision of psychotherapy assessment and treatment; accepting electronic payment; and obtaining PFW Release of Information or any other documentation relevant to psychotherapy treatment as deemed necessary. If you choose to consent to telehealth, Doxy.me will send an invite from your clinician to your email address or SMS according to your preference as discussed with your clinician. Forms will be exchanged via Doxy.me to your preferred email address or SMS. Payments may be accepted via Doxy.me by a 3rd party entity, Stripe.com., and is optional service.

**If you do not wish to participate in telehealth services do not respond to this request and inform your clinician.**

If you wish to participate in telehealth services, please initial each of the following:

____ I understand that telehealth involves the communication of my mental health information in an electronic or technology-assisted format.

____I understand that I may revoke this consent at any time, and it will not change my ability to receive future care at Partners in Family Wellness, PLLC.

____I understand that even though Doxy.me is a HIPPA-compliant entity, all electronic medical communications carry some level of risk to confidentiality.

____I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

____I understand that Partners in Family Wellness, PLLC is not responsible for breaches of confidentiality caused by Doxy.me or me.

____I understand that electronic communication with Partners in Family Wellness, PLLC via Doxy.me may be used to provide psychotherapy, communicate consent, and for billing purposes.

____**I understand that electronic communication with Partners in Family Wellness, PLLC via Doxy.me should never be used for emergency communications or urgent requests.**

____I understand that mental health emergencies should be treated like medical emergencies and I should call 911 or go to my local emergency room.

By signing below, I am consenting to participation in electronic exchange with Partners in Family Wellness, PLLC via Doxy.me and understand the inherent risks and benefits to consenting to electronic communication.

_____

Patient Signature/Date

I attest that I have explained the nature of Partners in Family Wellness, PLLC's, electronic consent to _____. I have answered all questions fully and believe that the patient understands what I have explained.

_____

Clinician Signature/Date