Ginair Goodwin McKerrow, LCSW
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
404-983-3320

Telemedicine Informed Consent

I _____ hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) with Ginair Goodwin McKerrow, LCSW. The main venue for my psychotherapy treatment will be her office at the address listed above. I understand that telemedicine 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 telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

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

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally 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 towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine based services and care may not yield the same results nor be as complete as face- to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Georgia law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature:_____ Date:_____