

Robin S. Rosenberg, Ph. D., ABPP
5 Union Square West, #1119
NY, NY 10003
DrRobinRosenberg.com

Robin@DrRobinRosenberg.com

650-440-5534

Licensed in: CA #24085, MA #4604, NY #021395, UT #10834698-2501

Telehealth Policy

In the case where we are unable to meet face-to-face, do you consent to engaging in contacts by phone or video (telemedicine) with me as part of your psychotherapy? ☐ YES ☐ NO

When the answer is "YES": In the case where we elect not to meet face-to-face, I _____ hereby consent to engage in contacts by phone or video (telemedicine) with Dr. Rosenberg as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand if I release my confidential information to specific persons, that telemedicine may also involve the communication of my medical/mental health information, both verbally and visually, to health care practitioners located in California or outside of California.

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.
- 2) The laws that protect the confidentiality of my medical information also apply to telemedicine. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to the situations listed in the Registration Form. 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, including but 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; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine-based services and care may not 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 services (e.g., face-to-face service) I will be referred to a psychotherapist who can provide such services in my physical location, if possible.
- 4) I understand that I may benefit from telemedicine, but results cannot be guaranteed.
- 5) I understand my insurance may not cover telehealth services and I am responsible financially.

I have read and understand the information provided above. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

Signature/Date

I have been offered a copy of this and ☐ accepted/ ☐ declined