

TELEHEALTH INFORMED CONSENT

As a patient or the parent/guardian of a patient receiving mental health services through telehealth, I understand that telehealth services are provided by teleconferencing, phone, text, and email.

TECHNOLOGY/EQUIPMENT: Dr. Chidekel uses a secure, HIPAA-compliant video platform for teleconferences. Prior to a session, she will email me a link to allow me to access her virtual “office.” I will need a working webcam and speakers or headphones, and a PC or Mac or iPad. A Chromebook, iPhone cellular phone or other internet-enabled device will not work. The webcam needs to be adjustable so Dr. Chidekel can, at times, focus on a document on which I’m writing without my having to hold the camera in this position. The quality of communication will depend upon the reliability of the telehealth platform, my own internet connection, and Dr. Chidekel’s internet connection.

TESTING: I understand that remote administration of tests departs from the standard conditions under which the test norms were established. Meeting via telehealth will also preclude Dr. Chidekel from gathering some of the qualitative information that she would get from observing me during an in-person exam. Dr. Chidekel will not administer any test to me remotely if she believes its interpretability would be grossly compromised by this mode of administration, but I understand that these limitations of telehealth may reduce the richness of the clinical information available to her, impact confidence in her diagnostic conclusions, and impact recommendations she makes for treatment.

ADMINISTRATIVE IMPLICATIONS: I understand that results from testing administered via telehealth may not be acceptable by organizations to which I plan to submit results for the purposes of seeking workplace or testing accommodations or for documenting a diagnosis. I will address these concerns with Dr. Chidekel ahead of time.

ENVIRONMENT: Dr. Chidekel will discuss the environment needed for telehealth testing to be conducted, including the level of oversight that I will need provide if she is assessing a child or a dependent adult. It will be my responsibility to maintain privacy and a controlled, quiet environment. I will act in advance to minimize foreseeable disruptions by family members, animals, or others; and predictable sources of noise, such as scheduled leaf-blowing, telephone calls and text alerts. In the event that such foreseeable disruption(s) occur(s) and are of a number or magnitude to compromise Dr. Chidekel’s ability to provide quality services, the session will be terminated. I may reschedule the time at my cost.

MAINTAINING TEST SECURITY: Dr. Chidekel will send me an envelope of test forms and materials prior to my first testing appointment. I will wait to open the envelope per her direction in that first session. I will not copy or document the content of any of the materials she provides me, and I will not copy or record any material that’s provided on my computer screen/monitor, such as by taking “screenshots” or copying and pasting. At the conclusion of the last testing session, Dr. Chidekel will direct me to make an electronic copy of the test forms I’ve completed, and to send them to her via email. After she confirms receipt, I will immediately destroy testing forms and materials. Neither Dr. Chidekel nor I will make an audio or video recording from the telehealth session.

INSURANCE: I understand that telehealth services may not be a covered benefit under my insurance plan.

CONFIDENTIALITY: I understand there are risks when transmitting information over the internet. These include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties, which may not be under Dr. Chidekel’s control.

RIGHT TO WITHDRAW CONSENT: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.

COMPLIANCE WITH LAW: I understand that telehealth services must comply with State and Federal (HIPAA) law.

By signing below, I indicate that I understand and agree to these provisions of care via telehealth.

Signature _____ Name _____ Date _____

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