CONSENT & AUTHORIZATION FOR TELEHEALTH SERVICES

We at The Mauriello Group strive for client growth and improvement. It is our goal and desire to work with clients so that they may gain the capacity to resolve their own challenges. Together with your healthcare professional, we hope that you will feel confident that you are able to face both your immediate challenges and the ones you will face in the future. The needs of our clients vary greatly, but together, our team will work to help you close the distance between where you are today and goals you strive to reach. As such, treatment may only be for several sessions, while other treatment programs can run for months or years. Together, we will work to achieve the best possible results for you.

Client Agreement and Contract

Services known as "telehealth" include the use of synchronous video and audio technologies to support long-distance healthcare between providers and their clients. In this case it is the delivery of behavioral healthcare services with the provider and recipient of services being in separate locations, but at the same time.

I hereby authorize and voluntarily consent to receive telehealth services from *Matthew J. Mauriello, MA, P.C.* (DBA "The Mauriello Group") as provided by _____, Pennsylvania license number _____.
My signature below indicates the following:

- I understand I will need access to certain technological tools to engage in telehealth services with my provider(s). These tools are "cloud-based," meaning the records are stored on servers that are connected to the Internet. My provider(s) only uses HIPAA-compliant tools that employ technological and physical safeguards to protect my health information.
- I understand that telehealth has benefits such as receiving services at a convenient time or location as well as improving progress on treatment goals that might have been less successful without telehealth.
- I understand that telehealth has risks such as Internet connections and cloud-based services could cease working; cloud-based service personnel, IT assistants, and malicious actors (i.e., "hackers") may have the ability to access private information that is transmitted or stored in the process of telehealth-based service delivery; or devices can have sudden failures or have power interrupted.
- I understand that it is possible that receiving services by telehealth will turn out to be inappropriate for me, and that my provider(s) and I may have to cease work by telehealth because of my behavior and/or medical condition worsening.
- I understand I can stop work by telehealth services at any time without prejudice.
- I understand I will need to participate in creating an appropriate space that is safe, confidential, and free of distractions with reliable access to Internet (i.e., bandwidth of at least 10 MBPS) for telehealth services.
- I understand that I will need to have access to the following equipment: a computer, tablet, or smartphone; an external or integrated webcam; and an external or integrated microphone.
- I understand that my provider(s) will verify my identity prior to each telehealth session.
- I understand that my provider(s) and I will determine if my location is safe and appropriate prior to each telehealth session.
- I understand I will need to participate in making a plan for managing technology failures and medical emergencies. I will designate an emergency contact, and authorize my provider to communicate with this person about my care during emergencies.
- I understand my provider follows security practices and legal standards in order to protect my healthcare information, but I will also need to participate in maintaining my own security and privacy. I will use devices and service accounts that are protected by unique passwords that only I know as well as use the secure tools that my provider has supplied for communications.
- I understand I that I am to not record video and/or audio sessions without my provider's consent because such recordings can quickly and easily compromise my privacy. I understand that my provider will not record video or audio sessions.

CLIENT NAME/ID: _____

As the client and/or personal representative(s) of a client of *Matthew J. Mauriello, MA, P.C.*, the above information and policies have been fully explained to me. As the presenting legal guardian (if applicable), I have authority to consent to behavioral healthcare services for my child. I hereby authorize and consent to said treatment and/or assessment(s), and I hereby authorize the receipt and disclosure of information about me and/or my child to any party whatsoever, as stipulated above by *Matthew J. Mauriello, MA, P.C.*

Printed name of client	Signature of client (if age 14 or older)	Date
Printed name of personal representative	Personal Representative Signature (client under 18)	Date
Printed name of personal representative	Personal Representative Signature (client under 18)	Date

I, the examiner and behavioral healthcare professional, have discussed the issues above with the client and/or the client's personal representative(s). My observations of this person's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed, willing, and voluntary authorization and consent.

Printed Name of Professional	Signature of Professional	Date