Celine Paillot, Ph.D. Psychological Services

652 Boston Post Rd Suite 8
Guilford, Connecticut 06437

Phone (230) 909-2418
Fax (480) 247-4658

TELEHEALTH INFORMED CONSENT

Name: Date of birth:

I hereby consent to engaging in telemedicine with Celine M Paillot Ph.D. as part of my psychological treatment. 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 the following rights and limitations associated with telemedicine:

(1) I have the right to revoke my consent to telemedicine at any time.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information I disclose during the course of my treatment is 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.

(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 Dr. Paillot, 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.

(4) In addition, I understand that telemedicine-based healthcare may not be as complete as face-to-face services. I also understand that if Dr. Paillot believes I would be better served by direct (i.e. face-to- face) interaction and if I am unable to meet with her face-to-face, I will be referred to a clinician who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatric treatment, and that despite my efforts and the efforts of Dr. Paillot, my condition may not improve or may worsen.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Connecticut law.

I have read and understand the information provided above. I have had the opportunity to discuss it with Dr. Paillot and all of my questions have been answered to my satisfaction.

Signature of Patient or Parent/Guardian **Date**