Jeffrey Bernstein, Ph.D.
Licensed Psychologist
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Telehealth Consent Form

I, ____

(Name) (Phone number) (email address)

Client Name: ______________________________________

1. I understand that my mental health care provider, Dr. Jeffrey Bernstein, wishes me to engage in a 50 minute telehealth consultation/counseling session, that the fee is $280.00, and is to be paid prior to or at the time of services, payable through Venmo or cleared check before the session. Please note that if you wish to pay by credit card or PayPal, the fee is $290.00.

2. I understand that the video conferencing technology will be used to affect such a consultation will not be the same as an in-office visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4.I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telemedicine consultation.

5. In an emergent consultation, I understand that if I cannot reach Dr. Jeffrey Bernstein, I will call 1-800-273-TALK (8255) or go to my local hospital emergency room.

6. I have had a had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

7. While I am free to take notes during and after sessions, I understand that audio or video recording of sessions is prohibited.

By signing this form, I certify:
- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to
my satisfaction.

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Patient/parent/guardian signature and date