

# Jeffrey Bernstein, Ph.D.

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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 \$250.00, and is to be paid prior to or at the time of services.
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.

\_\_\_\_\_  
Patient/parent/guardian signature and date