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INFORMED CONSENT FOR TELEHEALTH SERVICES

Telehealth services involve the use of electronic communications (video conferencing) to enable therapists to provide services to individuals who may not have adequate access to health care. Telehealth may be used for services such as individual, family, couples therapy, parenting consultations as well as supervision and consultation on cases. Telehealth is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in-person. These limitations can be addressed and are minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc) is utilized. It is important that both client and therapist are located in a private place during their sessions, and that the security of their technology be up to date with appropriate security protection.

Since telehealth services nay be different that the sessions that you are familiar with, it is important that you understand and agree to the following:

1. I understand that my therapist will be at a different location from me and that telehealth may include electronic communication of my personal health information. My therapist has explained to me how the video conferencing technology will be used to provide services and discussed how this service will differ from direct, in-person patient/provider sessions.

2. I understand that there are potential risks to utilizing this technology despite reasonable efforts by the health care provider, including but not limited to, unforeseen interruptions in service, unauthorized access to electronic data, if the videoconferencing connections are not adequate for this situation. I have also discussed what to do if I experience technical difficulties or my telehealth session is unexpectedly interrupted.

3. I have had a conversation with my therapist, during which I had the opportunity to ask questions regarding telehealth services. My questions have been answered and the risks and benefits and practical alternatives have been discussed with me. I also understand that I have the option to stop telehealth services at any time without affecting future care or treatment. I also understand that telehealth services may not be recommended by my provider, or appropriate treatment for all patients or covered by all insurance companies.

4. I understand that it is my responsibility to contact my insurance and determine if I have coverage for telehealth. If I do not and still want to have telehealth sessions**, I understand that I am responsible for the full cost of the sessions.**

5. I understand that if an emergency situation occurs during a telehealth session, my therapist will call emergency services and my emergency contacts. I also agree that if I am advised to, I will go to the emergency room or call 911.

6. I understand the laws and standards of my therapist's profession require that they keep protected Health Information about me in their Clinical record, which apply equally to in-person and telehealth services. The content of the telehealth sessions is not recorded in any fashion, nor are they monitored or stored by any entity.

7. I understand the legal, regulatory and ethical rules governing confidentiality and privileged health information apply to telehealth services. I understand that despite my therapist's full compliance with HIPAA regulations and great effort to secure electronic personal health information, it is possible the transmission and storage of my personal health information

could be interrupted or accessed by unauthorized personals. I have spoken to my therapist about confidentiality in the context of telehealth services and had an opportunity to ask questions and raise concerns.

8. I understand that the laws and regulations vary in each state and that my therapist may not be able to provide telehealth services when I am in certain states. I understand that the laws pertaining to limits of confidentiality, mandated reporting, duty to warn and involuntary hospitalization still apply.
9. I understand that telehealth services are intended to be used adjunctively with in-person services whenever viable and not to replace in-person sessions. Similarly, telehealth services are not intended as a replacement for cancelled or missed appointments. My therapist may require in person visits at certain intervals.
10. I agree to not record, save, publish, disseminate or electronically transmit any data, images, video, audio and/or any other aspect of the telehealth session.
11. I understand that I am responsible for securing a quiet, comfortable and private space suitable for telehealth services. I am also responsible for supplying sufficient technological resources, knowledge of how to use the necessary software and equipment, time to set up and participate in the telehealth session.
12. I understand that the cancellation and no-show policies apply to telehealth services.

I have read the statements above, understand the guidelines and agree to them completely. I hereby consent to telehealth services for myself and/or my child.

Patient's Name (please print) Date

Signature of adult client or parent/guardian Date

Telehealth Safety Plan

Client Name: _____

Physical Address of client during telehealth session:

Street_____

City_____ State _____ Zip_____

Client Phone number_____

Alternate Phone Number_____

Emergency Contact (1): _____ Relationship_____

Phone number: _____ City/State _____

Emergency Contacts (2): _____ Relationship _____

Phone number: _____City/State _____--

Local Hospital (local to client location)_____