Telehealth Service for Mental Health
Acknowledgement and Informed Consent

I, _____(Client Name), hereby consent to participate in Telehealth

Services with _____ (Provider Name) .

Definition: Telehealth Services means the use of information technology by a health care provider, such as a social worker or professional counselor, to deliver clinical services at a distance for the purpose of diagnosis, disease monitoring, or treatment. Telehealth Services require an audio component and a video, unless a video device is not available. Telehealth Services do not include the use of social media, texting or email.

What to Expect. If you agree to receive Telehealth Services, you will have a scheduled time to meet with me. At that time, you will either receive a call from me or log on to a secure videoconferencing app. You will need to use your own device, such as a smartphone, tablet or computer to connect with me. I recommend that you find a private, quiet space where you will not be interrupted and where you can speak without being overheard. We will then proceed with the session, just as we would if we were face to face in the same room.

During a Telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss. We may have to re-schedule.

Risks and Benefits. There are risks, benefits and consequences associated with Telehealth. The same risks that apply with respect to counseling services in general also apply to Telehealth Services. With Telehealth Services, there is risk of disruption or distortion from technology failures, that the communication will not be as easy and natural, or that breaches of confidentiality could occur. I also have a more limited ability to respond to emergencies.

The benefit to Telehealth Services is that you can continue to receive services, and that you can receive these services without risk of exposure to the COVID-19 virus.

You have the following rights with respect to Telehealth Services:

(1) Telehealth Services are voluntary. You have the right to decline to receive Telehealth Services without affecting the right to future care or treatment and without risking the loss or withdrawal of program benefits to which you would otherwise be entitled.

(2) You have the right to confidentiality of your protected health information. I am required to (a) prevent the unauthorized disclosure of an identifiable image of you and (b) prevent the disclosure of any other confidential information obtained during a Telehealth session. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required

by law. (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; mental/emotional health raised as an issue in a legal proceeding). There will be no recording of any of the online sessions by either party.

(3) You have the right to access the same information generated in a record of the Telehealth Services, as you would have the right to a record generated from the same health services provided face-to-face in the same room.

Emergency Protocols. I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

Emergency Contact person's name, address, phone: _____

_____

Acknowledgement and Consent to Receive Telehealth Services

By signing below, I am confirming that I have received the above educational information regarding Telehealth Services, that I have had a chance to ask questions and have had all of my questions answered to my satisfaction.

I confirm that I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

I also confirm that I wish to receive and consent to Telehealth Services.

Client Signature: _____

Client Name: _____

Authorized Representative Name (if applicable):_____

Authorized Representative Signature (if applicable)

Date: _____

Provider Signature: _____

Explain if Consent received Telephonically:

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