



INFORMED CONSENT FOR TELEHEALTH

Introduction to Telehealth

- Telehealth is the delivery of therapy/psychiatry using interacting technologies (e.g., audio, video, or other electronic communications) between a practitioner and a client who are not in the same physical location.
- The interactive technologies used incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and protect against intentional or unintentional corruption.

Benefits of Telehealth

- A client and practitioner can engage in services without being in the same location.
- It is more convenient and takes less time (i.e. there is no travel involved).

Technology Requirements

- I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. This includes the necessary electronic device and internet access.
- I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network.

Client Responsibilities

- I understand that it is my responsibility to maintain privacy on the client end of communication. This includes arranging a location that is free from distractions and has sufficient lighting.
- I understand that at the start of our telehealth session I will provide the address of my current location (in case of an emergency).

Risks

- I understand that there are risks in using technological service delivery including the possibility that:
 - technology may fail before or during the consultation,
 - transmitted information may be unclear or inadequate for proper use in the consultation,
 - information may be intercepted by an unauthorized person or persons.
- Specific risks to confidentiality may include:
 - breaches of confidentiality
 - theft of personal information

Confidentiality

- I understand that the laws that limit my rights to confidentiality within in-person treatment sessions also apply to telehealth sessions.

Emergency Protocol

- I understand that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telehealth consultation.
- In that event, I agree to seek care immediately by proceeding to the nearest emergency department or by calling 911.

Records

- The telehealth session will not be recorded in any way unless agreed to in writing by mutual consent.
- I understand that my telehealth session will be documented in the same way that it is maintained for in-person sessions in accordance with clinic policies.

Fees

- The same fee rates will apply for telehealth as for in-person sessions. If I am using insurance, I will still be responsible for payment of all deductibles and co-pays as defined by my insurance coverage.
- I am aware that insurance or other managed care providers may not cover sessions that are conducted via telecommunication.
- If a third-party payor does not cover telehealth services, I understand I will be responsible for the fee. I have been encouraged to contact my insurance company prior to engaging in telehealth in order to determine whether these sessions will be covered.

Self-Termination

- I may withhold or withdraw consent for telehealth services at any time without jeopardizing my access to future care, services, and benefits.

By signing this form, I certify that:

- I have read this document carefully and fully understand the benefits and risks.
- I have had ample opportunity to ask questions and have received satisfactory answers.
- I voluntarily consent to participate in telehealth sessions.

Client Name (printed) Client Date of Birth

Parent/Legal Guardian Name (if signing on behalf of client) Date

Signature of Patient and/or Client/Legal Guardian if Patient is < 18 years of age Date

Signature of Child (when age ≥ 14) Date