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Consent for Tele-Health Services

Client Name: _____ Date: _____

Email address: _____ Phone:_____

I understand and agree to the following with respect to medical/mental health services:

- My provider uses a secure, HIPPA and HITECH compliant video telehealth platform known as Zoom, Doxy.Me or Psychology Today for Telehealth. I will need internet access, using a computer, tablet or smart phone (larger screens are generally better). If none of these are available to me, or if technical problems interfere with video communication, telehealth services may be conducted by telephone in certain situations. I have discussed the risks, benefits, and specific application to my treatment of each of these technologies with my provider. It is up to the provider to determine if these services are clinically appropriate.

Privacy and confidentiality are shared responsibilities of the provider and the client. It is my responsibility to maintain privacy on the client end of communication. I agree to use reasonable security protocols to protect the privacy of my own health care information. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree not to record video or audio sessions without my provider's consent. Making recordings can quickly and easily compromise my privacy and should be done only with great care. My provider will not record video or audio sessions, unless otherwise consented to and agreed upon.

The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, the information disclosed by me in the course of mental health services is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self or an identifiable victim; and defending claims brought by the client against the provider.

There are risks and consequences from telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons: and/or the electronic storage of my medical intonation could be accessed by unauthorized persons. These risks are offset by my provider's use of HIPAA/HITECH compliant service which is encrypted for video telehealth communications, and HIPAA/HITECH compliant Electronic Health Records systems. Further, the contents of my provider's computer are encrypted.

In addition, I understand that telehealth services and care may not yield the same results nor be as effective as face to-face service. I understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. in-person), I will be referred to a provider in my area who can provide such service. My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

I understand that it is my responsibility to check with my insurance plan to determine coverage of telehealth services.

I have the right to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retribution, and to refuse treatment, without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means, including telephone or secure email. I understand that SMS text messaging (e.g., through my cellular carrier) and nonencrypted email are not secure and should not be used to convey protected health information. All textual messages I exchange with my provider (e.g. emails and text messages) will become a part of my health record.

As a recipient of telehealth services, I will need to participate in ensuring my safety during mental health crises, medical emergencies, and sessions that I have with my provider. I agree to designate an emergency contact person, with whom my provider will be permitted to communicate about my care during emergencies. I understand that I can withdraw that permission at any time, but this will mean my provider will be unable to continue telehealth services at that time.

I acknowledge, however, 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. Instead, I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.

I hereby acknowledge that my questions have been answered to my satisfaction, and that I understand and agree to all of the above. I give my permission to Insight and Empowerment, LLC to provide me with psychotherapy, counseling, family counseling, and any other mental health treatment services deemed medically necessary, via telehealth, as described above.

This form may be signed by the client/responsible party and return via fax, email, or mail.

Client's Signature: _____
Date: _____

Parent/Guardian Signature:_____
Date: _____