MASTERPEACE
Center for Counseling & Development

INFORMATION & CONSENT FOR TELEHEALTH TREATMENT

Telehealth is live two – way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

- I understand that telehealth services are completely voluntary and that I can withdraw this consent at any time. I understand that none of the telehealth sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
- I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100% guaranteed to be secure.
- I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the telehealth technology is not adequate for the situation.
- I understand that if there is an emergency during a telehealth session, my therapist may call emergency services and/or my emergency contact.
- I understand telehealth is NOT an emergency service. In the event of an emergency, I will call 9-1-1 or go to my local emergency room.
- I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and all office policies and procedures apply to telehealth services.
- I understand that if the telehealth connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time to reconnect.
- I understand a no show or late fee will be charged if I miss an appointment or do not cancel the appointment 24 hours in advance. I understand credit card or other form of payment will be established before the first session.
- I understand my therapist will advise me what telehealth platform to use and will establish a video conference session for me to connect to.

_____ _____

Signature *(Parent/Guardian must sign if client is under 18 years old)* Date

_____ _____

Print Client's Name Client's Date of Birth

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Print Parent/Guardian Name (if minor)