Tree of Life Counseling Services, LLC

Office Locations

Rochester Hills	*Oxford*	*Troy*
1460 Walton Blvd.	837 S Lapeer Rd	1700 W Big Beaver Road
Suite 60 (Main Office) & 20	Suite 204	Suite 200
Rochester Hills, MI 48309	Oxford, MI 48371	Troy, MI 48084

Lenox	*Livonia*
36555 26 Mile Road	39000 W Seven Mile Road
Suite 3700	Suite 3600
Lenox, MI 48048	Livonia, MI 48152

TELEHEALTH SERVICE STATEMENT & AGREEMENT

"Telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the client and therapist are at two different sites. This form of service is usually live videoconferencing through a personal computer with a webcam. Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, and education using interactive audio, video, or data communications.

Please review the following **Telehealth Service Statement & Agreement**:

I understand that I must be in a quiet and private location, free of distractions to participate in telehealth services and that it will require access to proper technological resources that will be outlined by my provider.

I understand that to participate in telehealth my provider and I will determine a proper protocol or alternate therapeutic resources in the event that an emergency or crisis event might occur.

I understand that I have the right to withhold or withdraw consent at any time without affecting my access to future care or treatment, pending it can be provided safely and competently via an alternate modality of service.

I understand that the information disclosed by me during the course of my therapy is generally confidential except in those cases when 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 an ascertainable victim; and where I am the subject of a court order/subpoena.

I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, 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 information could be accessed by unauthorized persons.

I understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to an alternate medical or mental health service/resource.

I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

I understand that I have a right to access my medical information and copies of medical records in accordance with Michigan law and when requested in writing. As such, I assume all liability should my records be misplaced.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

PATIENT NAME (Printed): _____

CONSENT FOR TREATEMENT VIA TELEHEALTH: _____ _____

Patient / Responsible Person Signature* Date

**Electronic Signature*

You understand and agree that your electronic consent (including any electronic symbol) is your electronic signature, represents your agreement to the terms and conditions of this agreement, constitutes a valid signature, and shall have the same legal validity and enforceability as a manually executed signature or use of a paper-based record keeping system to the fullest extent permitted by applicable law.