TELEHEALTH INFORMED CONSENT

I, , hereby consent to participate in tele-mental health with, Joyce Wagner, Ph.D., LCSW-R/Restoration Counseling of Rochester, as part of my psychotherapy. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to tele-mental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that I may reimbursed less by my insurance company by using tele-mental health.
4. I understand that there will be no recording of any of the online sessions by either party. 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.
5. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
6. 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 tele-mental health services are not appropriate and a higher level of care is required.
7. I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, please call me at 585-733-9465 to discuss since we may have to re-schedule.
8. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

If you are having an emergency and I am not available, please call 911. 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 (*town/state*):
My emergency contact person's names is:
Their address is:

Their phone number is:

RECEIPT & ACKNOWLEDGEMENT OF TELEHEALTH INFORMED CONSENT

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of Client **Date**

Signature or Parent, Guardian or Personal Representative * **Date**

* *If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).*

☐ **Patient/Client Refuses to Acknowledge Receipt**:

Signature of Staff Member **Date**