



Virtual Visit Informed Consent

Tele-mental health is a live, two-way audio and/or video method of communication that allows therapists and clients to meet outside of a physical office setting. There are both benefits and limitations to tele-mental health services. You must have a TherapyNotes Patient Portal and a device that allows video and audio to participate in this service. All documents must be completed through the TherapyNotes Patient Portal. If you have not signed up for the Patient Portal yet, please advise your therapist so a link can be sent to you for registration.

Client Understanding

I understand that tele-mental health services may not be covered by my insurance company and that it is my responsibility to check with my insurance company to determine eligibility for this service.

I understand that tele-mental health services are completely voluntary and that I can withdraw this consent at any time. You or your therapist may discontinue the tele-mental sessions at any time if it is felt that the video technology is not adequate or clinically appropriate for the issues being addressed in treatment.

I understand that tele-mental health services are not appropriate for crisis or emergency situations. If there is an emergency during a tele-mental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand my therapist will advise me about what tele-mental health platform to use and will establish the video conference session.

I understand that none of the tele-mental health 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 tele-mental health.

I understand that if I want to have anyone else present during the tele-mental health session the therapist must be informed and the additional individual will need to sign this document. In order to ensure your safety and privacy, please do your best to participate in your telehealth visit from a private location.

I understand that tele-mental health services rely on technology and that there are risks in transmitting information over the internet. These risks may include breaches of confidentiality, theft of personal information, and disruption in service due to technical difficulties. While every effort has been made to mitigate these risks, the privacy and confidentiality of tele-mental health cannot be completely guaranteed.

I agree that my therapist and any LLC contracted with MCA 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 that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to tele-mental health services.

I understand that if the video conferencing connection drops while I am in a session, my therapist will attempt contact again via video or my phone number on file if video is not working. # _____

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of the scheduled appointment.

I understand credit card authorization must be signed and on file before the first session to pay for services rendered.

Client Name: _____ Date: _____

Parent/guardian signature (For Client's 13 years and younger): _____