VIRTUAL VISIT INFORMED CONSENT

This statement of understanding is aimed at helping you understand policies and procedures related to telehealth or virtual visits provided by this agency. As a Madison Counseling Associates client receiving counseling services through telehealth, you understand the following:

- Telehealth visits are provided using technology, which may include video, phone, text, and email, and will not involve direct, face-to-face interaction. There are both benefits and limitations to telehealth services. You must have access to appropriate technology/devices to participate in this service. As interaction will not be face-to-face, any paperwork exchanged will likely be through electronic means or through postal delivery.
- Telehealth may not be covered by your insurance – please check your policy.
- Telehealth will require you to have a Consent for Credit Card on file.
- If the need for face-to-face services arises, it is your responsibility to inform your clinician or to contact this office for a face-to-face appointment. Please understand that there may not be an immediate opening, but we will see you as quickly as possible.
- You may decline telehealth services at any time without impacting your access to future care.
- Telehealth services rely on technology, which allows for greater convenience in service delivery. However, there are risks in transmitting information over the internet. These may include breaches of confidentiality, theft of personal information and disruption in service due to technical difficulties. While encryption measures have been taken by this office to protect the information that will be communicated between you and your clinician, the privacy and confidentiality of computer mediated communication cannot be 100% guaranteed. This office and your clinician will take every measure to safeguard your information, but you should be aware there is a small chance your information could be compromised.
- Please be aware that psychologists, counselors, and social workers have a legal and ethical duty to warn if there is an indication patient is a danger to him/herself or to others. Please provide the number for your emergency contact here: _____.
- Telehealth visits provide convenience and many advantages for some patients. However, not all issues or problems are clinically appropriate for telehealth services. Your clinician may recommend face-to-face services for specific issues or therapeutic techniques. You and your clinician will regularly reassess the appropriateness of telehealth visits for you.
- Any family member or other individual you would like to have present during your telehealth visit must also 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. All individuals present for your telehealth session must be identified so the clinician is aware of everyone participating.
- In the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. Please provide us with your call-back number in the event the session is interrupted: _____. Should service be disrupted, you may also contact our office at 256-542-3288.
- Telehealth visits should not be used for emergency mental health needs. Our staff responds to communications and routine messages within 72 hours. In emergency situations call 911 and/or go to the nearest emergency room.
- It is your responsibility to maintain privacy on your end of communication. Insurance companies, those authorized by the client and those permitted by law may also have access to telehealth records or communications. All information regarding communications will be maintained in accordance with HIPAA standards. Communications exchanged with your provider will be kept in your electronic medical record.
- The laws and professional standards that apply to face-to-face psychological and counseling services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I consent to telehealth visits with my clinician _____.

PATIENT NAME: _____ DATE:_____
GUARDIAN IF APPLICABLE: _____ DATE:_____

OTHER ATTENDEE: _____ DATE: _____