**INFORMED CONSENT FOR ONLINE THERAPY SERVICES**

**ONLINE THERAPY AGREEMENT**

Online therapy is a digital mental health solution that connects patients and clinicians using real-time audio-video technology. It includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. InTouch Mind Health, LLC uses online therapy as an alternative to traditional in person care. Using secure technology clinicians can provide secure quality care for patients. In some cases, when a patient is unable to access an adequate device to connect online, a clinician may connect with patients using a voice-only option (such as telephone, also known as telehealth).

**BENEFITS OF ONLINE THERAPY**

InTouch Mind Health, LLC appreciates online and telehealth therapy options as practical, efficient, and effective alternatives for care which benefit patients by reducing the burden of traveling to and from therapy, allowing mental health providers to extend patient access to care beyond normal clinic hours, and aids in overcoming clinician shortages in rural and underserved populations.

**PATIENT RIGHTS TO PRIVACY**

I understand that the laws which protect the confidentiality of my personal information also apply to online therapy. As such, I understand that the information disclosed by me during my sessions is confidential with some legal exceptions, including, but not limited to, instances where an expressed threat of violence toward an ascertainable victim exists, the reporting of child, elder, and dependent adult abuse, and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable information (including images) from my online therapy sessions to other entities shall not occur without my written consent. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes, but my expressed written consent is required to forward my personally identifiable information to a third party. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state of my legal residence. I understand that InTouch Mind Health, LLC utilizes secure, encrypted audio/video technology to deliver online therapy and that reasonable efforts will be made, in keeping with privacy laws, to reduce the risk of my sessions and/or personal information being interrupted, disrupted, distorted, or lost by technical failures and/or accessed by unauthorized persons.

**AGREEMENT**

By signing this form, I am agreeing to participate in video-therapy using video conferencing technology as explained above. I also understand that at my request or at the direction of my clinician, I may be directed to in-person psychotherapy. I understand I have the right to withhold or withdraw my consent to the use of online therapy during my care at any time, without affecting my right to future care or treatment. I further consent and agree, that if my mental health clinician believes I would be better served by another form of intervention (e.g., in-person services), he/she will work with me to transition from online therapy to in person therapy. If a location suitable to me is not available with my clinician, I will be referred to a different mental health professional, either within the InTouch Mind Health, LLC group, or outside of the group for in-person consultations that are suitable for me. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video /computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (12 years old or older)

Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Treatment of minors with divorced parents who have joint custody, requires signed consent by both parents. One parent has sole custody of a child, only the signature of the parent with full (sole) custody is required. A copy of the divorce decree should be filed in the patient’s chart. Where patient has a Healthcare Power of Attorney (POA), the POA must sign. A copy of the POA must be filed in patient’s chart.