Grace C. Mae
ADVOCATE CENTER

Telemedicine Informed Consent

I, _____, hereby consent to my child, _____, to engage in telemedicine (e.g., internet or telephone-based therapy) at the Grace C Mae Advocate Center as the main venue for my child's psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I and my child (we) have the following rights with respect to telemedicine:

(1) We have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which we would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, we understand that the information disclosed by me or my child during the course of my therapy is generally confidential. However, 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 we make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

We also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) We understand that there are risks and consequences from telemedicine. These may include, but are 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; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, we understand that telemedicine based services and care may not yield the same results nor be as complete as face-to-face service. We also understand that if my psychotherapist believes we would be better served by another form of psychotherapeutic service (e.g. face-to-face service), we will be referred to a psychotherapist in my area who can provide such service.

Finally, we understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) We understand that we may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) We understand that we have the right to access my medical information and copies of medical records in accordance with Iowa law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated. Iowa law prohibits children's session notes from being disclosed to parents or third parties.

(6) I understand that I am responsible for any out-of-pocket expenses not covered by insurance for teletherapy services. Failure to pay these expenses may and can result in termination of teletherapy services and referral to the patient accounts department for collections purposes, which will include additional fees. Payment is expected at the time of service of service and can be paid with a credit or debit card.

We understand neither the Therapist nor the Patient will record any teletherapy session.

We have read and understand the information provided above, which has also been explained to me verbally. We have discussed it with my psychotherapist, and all of our questions have been answered to our satisfaction.

Parent Signature: _____ Date: _____

Patient Signature: _____Date: _____

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

Teletherapy Crisis Plan

In the case of an emergency or escalating crisis due to the status of my child's mental health, I understand my therapist may need to contact my designated crisis support system. Releases of information are on file with my signature and consent to contact these supports. However, in addition, my child may need emergency personnel to be called in the event that he/she is escalating to imminent risk. Although this is a rare situation, legal statutes and ethical guidelines prohibit teletherapy from occurring without having a written crisis plan, and to have my child's location and phone numbers reviewed at the beginning of each teletherapy session.

My child's emergency contact support person is:

_____ Phone: _____

My child's local non-emergency service number is:
(Therapist cannot call 911 from originating location)

Parent Signature: _____ Date: _____

Patient Signature: _____Date: _____

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance

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