Aspire Wellness

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Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician and practice, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Aspire Wellness utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.
4. I agree to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session, and will use a secure internet connection rather than public/free wifi.
5. I agree to use the back-up plan that I have set with my clinician (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
6. I have provided my clinician with at least one emergency contact and the closest ER to my location, and agree to have them contacted in the event of a crisis situation.
7. If not an adult, my parent or legal guardian has provided their consent and contact information.
8. If I normally use insurance to pay for sessions at the center, I have confirmed with my insurance company that the video sessions will be reimbursed, and if they are not reimbursed, I am responsible for full payment.
9. 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.

Client Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician, and all of my questions have been answered to my satisfaction. I have read this document

carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Patient Name: ___________________________ Date of Birth:_______________________

Patient Signature:____ Date: _____________