## **Adult, Child & Family Counseling**

**Telemental Health Informed Consent**

# **Definition of Telemental Health Services**

Telemental Health Services is the delivery of health care services through the use of interactive video and/or audio technology, permitting real-time communication between the client and the therapist, for the purpose of diagnosis, consultation, and/or treatment.

We feel it is important that, as our client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have read and understand the practice policies of this therapy in helping you make and informed decision about entering telemental health therapy.

1. I understand the same rights to confidentiality and limits to confidentiality that apply in face-to face sessions also apply to telemental health therapy. I understand that, due to legal or ethical obligation, specific circumstances may require my therapist to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) my therapist believes I may be a danger to myself or to others; b) my therapist believes that a child, elderly, or disabled person may be subject to abuse or neglect; and/or c) a court order exists that information regarding the therapy process be provided.
2. I understand that telemental therapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. I understand that my therapist is not able to connect me directly to any local emergency services.
3. I understand that I am responsible for (1) providing the equipment and internet access for my telemental health therapy sessions, (2) the security of my electronic device, and (3) arranging a location with sufficient privacy that is free from distractions or intrusions for my therapy session(s).
4. I understand that there are potential benefits by participating in telemental health, including: a) continuity of care from my current therapist when circumstances do not permit face-to-face contact; b) the ability to receive care from a therapist when circumstances do not permit face-to-face contact. I understand that no results can be guaranteed or assured. Despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may get worse.
5. I understand that there are potential risks by participating in telemental health. My therapist utilizes secure audio/video transmission software to deliver telemental health services. However, risks might still include unintended breaches of confidentiality such that the transmission of my personal information could be interrupted by unintended, unauthorized, third persons.
6. Telemental health services provided by technology may not involve direct face-to-face communication. In this case, the exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal deliver.
7. Despite reasonable efforts on the part of the therapist, therapy sessions may be disrupted or distorted by technical failures or difficulties. I agree to hold harmless, my therapist, for delays in evaluation or for information lost due to such technical failures.
8. I understand my therapist will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed. If I believe I need direct, in-person services, it is my responsibility to contact a therapist in my area such as my therapist’s office for an in-person appointment or my primary care physician if my therapist is unavailable. I understand that an opening may not be immediately available in either office.

**Confirmation of Agreement**

*My signature below indicates that I understand and agree to the above terms and give my full and informed consent to receive telemental health services:*

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Signature of Client or Legal Guardian Date

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Client Printed Name