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Informed Consent for Telehealth Treatment

Client Name:_______________________________________ DOB:_______________

Introduction to Telehealth

Telehealth is a form of two-way, real time, video and audio conferencing, which provides therapy services to clients and their families. Electronic systems used is a high quality, real-time audiovisual link using HIPAA-compliant telehealth platform to protect the confidentiality of patient identification. However as with any other technology devices, we cannot guarantee confidentiality.

By signing this form, I understand the following:

1. I understand that it is my responsibility to ensure I am in a private space during telehealth sessions to protect my privacy.

2. I understand the risks of utilizing technology for therapy services including breaches in confidentiality, theft of personal information, and disruption of services due to technical difficulties.

3. If there is any disruption in the connection, the clinician will try to reestablish the connection however if the clinician IS unable to do so, he or she will call you immediately on your phone number on file.

4. **I understand that my clinician has the right to use his/her own judgement to determine if I am suitable and appropriate client for using Telehealth.**

5. I understand that my clinician may request me to be seen in the office as and when needed and I will comply with these requests.

6. I understand that the **first visit** will be a **face to face** visit in the office with therapist.

7. I understand and agree that telehealth session **will not be used for emergency visits or crisis intervention.** If in a crisis, please dial 911 or go to your nearest emergency room. After an emergency, **I agree to follow up in the office for a face to face visit.**

8. The laws and professional standards that apply to in-person psychological services all apply to telehealth services. This document does not replace other informed consents.

My signature below shows that I understand and agree with all of these statements.

_______________________________________ _______________________
Signature of Client (Parent or guardian for a minor child) Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_______________________________________ _______________________
Signature of Therapist. Date

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.