Informed Consent for TeleMental Health

Treatment Date:____

Referred by:____

Client Full Name:____

Date of Birth:____

Location of client:____

Mailing address of client:____

Physical address of client:____
(It is required that the client announce their location at each session, and it may be required that the client be at that same location for each session for the purposes of insurance payments.)

Phone Number:____________________Alternate Phone Number:__________________

Emergency Contact:____

Emergency Contact Phone Number:_______________________________________

Introduction to TeleMental Health Services

As a licensed mental health provider, our center is obliged to inform you that TeleMental Health services involve the use of electronic communications (telephone, written forms, text, e-mail, video conferencing, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. TeleMental Health may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting. TeleMental Health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are fairly minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the therapist be located in a private place during their sessions, and that the security of their technology be up to date with appropriate security protection.

Expected TeleMental Health Benefits

- Improved access to care by enabling individuals to remain in their community.
- Access to the expertise of a specific specialist.

Possible Risks

Risks include, but are not limited to:

- Information transmitted may not be sufficient (e.g. poor sound or resolution of images) to allow for appropriate treatment.
- Delays in treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a breach of privacy.

Additional Points for Client Understanding

1. I understand that TeleMental Health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
2. I understand that none of the TeleMental Health sessions will be recorded or photgraphed without my written permission.
3. I understand that the laws that protect privacy and the confidentiality of client information also apply to TeleMental Health, and that no information obtained in the use of TeleMental Health, which identifies me will be disclosed to other entities without my consent.
4. I understand that because this is a technology-based method sometimes it may be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential. That said, I understand there are potential risks to this technology, including interruptions. I understand that my therapist or myself can discontinue the TeleMental Health sessions if it is felt that the video conferencing, or telephone connections are not adequate for the situation.
5. I understand that TeleMental Health is done over a secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality.
6. My therapist has explained to me how the video conferencing technology and telephone procedures will be used. I understand that TeleMental Health sessions will not be exactly the same as an in-person session.
7. I understand that my demographic information may be shared with Sophia Center staff for scheduling, billing, and consultation purposes.

8. I understand that I may experience benefits from the use of TeleMental Health in my care, but that no results can be guaranteed or assured.

9. I understand that if there is an emergency during a TeleMental Health session, then my therapist will call emergency services and my emergency contact. I have provided a working telephone number and e-mail address to reach me if the video conferencing connection fails during a session. My therapist has provided me with a contact number and e-mail. If connections fail and therapist does not call or e-mail me back within 5 minutes, then I will call or e-mail my therapist.

Communication Addendum

Secure and private communication cannot be full assured utilizing cell/smart phone or regular e-mail technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted, or not permitted, and under what circumstances. Use of any non-secure technologies to contact your therapist will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which mode(s) of communication are permitted. This consent may be updated at any time should circumstances or preferences change. In the event that the client chooses not to allow non-secure modes of communication, contact will only be made on the therapist's secure portal site, via wire-to-wire phone, or mail.

Voice communication to client's cell phone and landline from therapist's cell phone or office landline for:

Scheduling appointments ____Permitted ____Not permitted
Appointment reminders ____Permitted ____Not permitted
Between session contact ____Permitted ____Not permitted

Contact via the client's e-mail, including attachments, for:

Scheduling appointments ____Permitted ____Not permitted
Appointment reminders ____Permitted ____Not permitted
Between session contact ____Permitted ____Not permitted
If permitted, list permitted e-mail address(es):____________________________________

____

TeleConferencing-based communication from therapist for:

Scheduling appointments ____Permitted ____Not permitted
Appointment reminders ____Permitted ____Not permitted
Between session contact ____Permitted ____Not permitted
If permitted, list permitted portal site(s):____

I understand the information provided above regarding TeleMental Health and communication. I have discussed the consent with my therapist or assistant as may be designated. I hereby give my informed consent for the use of TeleMental Health in my care.

Signature of Client (or Parent/Representative):__________________________________

Date:____

If authorized signer, relationship to client:_____________________________________

If unable to electronically sign:

______By marking this box I have agreed to consent to the use of TeleMental Health.

Signature of Therapist:____

Date:____

I have been offered a copy of this consent form (client's initials):____________________

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