Headway Therapy Psychology, PC

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6. Telehealth Treatment Consent Form

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

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 that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows: You understand that if you are having suicidal or homicidal

thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your emergency contact person and phone number here:

You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list your closest hospital and phone number here:

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list your closest police department and phone number here:

In the event of a mental health emergency

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.:

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:
- Call your emergency person
- Call the National Suicide Prevention Line: (800) 273-8255
- Call the Access and Crisis Line: (888) 724-7240
- Go to your nearest hospital emergency room
- Call 911

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

Client Consent

Client Name:

☐ I hereby give my informed consent for the use of telemental health in my care.

Date of Birth:

Email:

Phone Number:

Client Signature: