

Informed Consent for Telemental Health Treatment

Definition of Telemental Health

Telemental health services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable counselors 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. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a counselor in person. These limitations can be addressed and may be 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 counselor be in a place where there is the most privacy as possible during their sessions, and that the security of their technology be as up to date as possible with appropriate security protection.

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 photographed 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 that identifies me will be disclosed to other entities without my consent.
4. I understand that telemental health may be performed over a communication that is not encrypted (e.g. Skype, Facetime). My counselor and I will work together to choose the telemental health communication system/program that will work best for my needs. I do accept the risk that this could affect confidentiality.
5. My counselor has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telemental Health sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my counselor.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my counselor may discontinue the telemental sessions at any time if it is felt that the videoconferencing, text, email, or telephone connections are not adequate for the situation.
7. 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.
8. I understand that if there is an emergency during a telemental health session, as with an in-person session, my counselor will call emergency services and my emergency contacts if needed clinically necessary.
9. I understand that in advance of the telemental health session a plan will be in place about how to re-connect if the connection drops while I am in a session.
10. I understand that my counselor and I will create and have in place a safety plan in case of an emergency (see below).
11. I understand I have the right to withhold or withdraw this consent at any time.

12. I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.

Payment for Telehealth Services

Hope for a Better Tomorrow will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay the self-pay rate associated with their specific counselor.

Client Consent to the Use of Telehealth

I consent to engaging in telemental health as part of my treatment with Hope for a Better Tomorrow. I understand that “telemental health” includes the practice of health care delivery, diagnosis, transfer of personal health information via conversation, and psychoeducation using interactive audio, video, or data communications.

I understand the information provided above regarding telemental health. I have discussed the consent with my counselor and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemental health in my care.

Print Name

Client’s Signature

Date

Parent or Guardian Signature

Date

TELEMENTAL HEALTH SAFETY PLAN ADDENDUM

Client Name (first and last): _____

Physical Address of Client during telemental health sessions (primary address):

Street: _____

City: _____ County: _____ State: _____ Zip: _____

*(It is preferred that the client be asked their location at each session when using telemental health)

Client's Phone Number: _____

Emergency Contact (1): _____

Relationship: _____

Phone Number: _____

Emergency Contact (2): _____

Relationship: _____

Phone Number: _____

- I have provided two emergency contact numbers.
- If there is an emergency during a session, my counselor has permission to contact my emergency contacts.

Signatures:

Client

Date

Counselor

Date