TELEHEALTH CONSENT FORM

sacred art
COUNSELING & WELLNESS

I, _____ hereby consent to engage in Telehealth with_____. I understand that Telehealth is a mode of delivering health care services, including counseling, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. By signing this form, I understand and agree to the following:

1. I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person counseling. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my counselor also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my counselor, that my counseling sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

4. I understand that at the beginning of each Telehealth session my counselor is required to verify my full name and current location.

5. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my counselor may record the sessions without the other party's written permission.

6. I have discussed the fees charged for Telehealth with my counselor and agree to them [or for insurance patients: I have discussed with my counselor and agree that my counselor will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Informed Consent Form

7. I understand that my counselor will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my counselor may not be able to assist me in an emergency. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance. I have read and understand the information provided above, have discussed it with my counselor, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

Client's Signature_____ Date_____

Guardian's Signature_____Date_____

(If client is under 18 years old)

Counselor's Signature_____Date_____