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Informed Consent for Tele-Health

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

CONFIDENTIALITY

The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:
1. If a patient threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in treatment or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Consent for Telehealth Therapy

Introduction

Telehealth is the delivery of counseling services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location. The interactive electronic systems used in Telehealth incorporate network and software security protocols to protect the confidentiality of client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

POTENTIAL BENEFITS

• Increased accessibility to therapeutic care.• Client convenience.

POTENTIAL RISKS

There may be potential risks associated with the use of Telehealth. These risks include, but may not be limited to:•Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision-making by your provider.• Delays in therapeutic evaluation and treatment may occur due to deficiencies or failures of the equipment.• Security protocols can fail, causing a breach of privacy of confidential health information.• A lack of access to all the information that might be available in a face-to-face visit, but not in a Telehealth session, may result in errors in judgment.

CLIENT'S RIGHTS

I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth therapy.

I have the right to withhold or withdraw my consent to the use of Telehealth during the course of my care at any time.

I understand that my withdrawal of consent will not affect any future care or treatment.

I understand that my provider has the right to withhold or withdraw consent for the use of Telehealth during the course of my care at any time.

I understand that the laws that protect the privacy and confidentiality of medical information also apply to Telehealth.

I understand that the all rules and regulations that apply to the provision of healthcare services in the State of Indiana also apply to Telehealth therapy.

CLIENT'S RESPONSIBILITES

I will not record any Telehealth sessions without written consent from my provider.

I understand that my provider will not record any of our Telehealth sessions without my written consent.

I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for Telehealth sessions.

I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I understand that I must be a resident of the State of Indiana to be eligible for Telehealth services from my provider

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Signature Date