

TELEHEALTH INFORMED CONSENT

Telehealth is mental health provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, client portals, and remote client monitoring are all considered telehealth services.

Client's Initials

_____ I understand that telehealth involves the communication of my mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to clients, including myself, who are residing in the state of Pennsylvania at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my mental health provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by my mental health provider, and potentially the mental health facility involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, Zoom, Teams, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The mental health provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my mental health provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the mental health provider rendering my care via telehealth and to confirm that he or she is my mental health provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my mental health provider's ability to fully diagnose a condition or disease. As the client, I agree to accept responsibility for following my mental health provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when mental health care is provided.

_____ To the extent permitted by law, I agree to waive and release my mental health provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

Client

Date

Provider

Date