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CONSENT TO TELEHEALTH SERVICES

Client's Name: _____ **DOB:** _____

Client ID: _____ **Therapist:** _____

INTRODUCTION

"**Telehealth**" (also known as "Video Therapy" and "Telephone Counseling") involves the delivery of psychotherapy counseling services using electronic communications, information technology or other means between a mental health clinician employed by or otherwise contracted with TMG ("**Provider**") and a client who are not in the same physical location.

Telehealth may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- **Video Therapy:** therapy sessions provided via video conferencing
- **Telephone Counseling:** counseling sessions provided via telephone
- Electronic transmission of clinical records, photo images, personal health information or other data between a client and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of Video Therapy Services (Zoom and/or other HIPAA compliant platform) has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

STATEMENT OF POTENTIAL RISKS AND BENEFITS

Potential Benefits of Telehealth Services

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Potential Risks of Telehealth Services

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via Video Therapy. You may be required to seek alternative care. In this case, your Provider would offer you referral suggestions and resources to the best of her/his ability.
- Delays in clinical evaluation/treatment could occur due to failures of the technology.
- Security protocols or safeguards could fail causing a breach of privacy. If this were to occur, TMG would notify you promptly.

By accepting this Consent to Telehealth Services, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via Telehealth is an evolving field and that the use of Video Therapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of Telehealth Services may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using Telehealth Services, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these Telehealth services. My Provider cannot ensure my privacy at my location.
7. I agree that I will not record my sessions without prior written consent. Instructions for accessing my medical record have been outlined for me in the organization's Privacy Practices.
8. I agree and authorize my Provider and TMG to share information regarding my Telehealth treatment with other individuals for treatment, payment and health care operations purposes as allowed by law.
9. I agree and authorize TMG and/or Zoom (or any other HIPAA compliant platform used) to provide me with technical support if I request it.
10. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment.
11. If my health insurance provider does not reimburse for provision of Telehealth Services, I may be solely responsible for covering the costs of my Video Therapy Counseling, as outlined in the form "Agreement for Payment and Financial Responsibilities."
12. I understand that my Provider may only utilize Video Therapy for my treatment when I am located in the state of my residence and/or in which the Provider has authorization or licensure to practice. As such, my Provider will ask to verify my location at the beginning of sessions.
13. I understand the need to participate in Telehealth Services from a secure, private location to the best of my ability. I will communicate any privacy limitations to my Provider at the beginning of the session.
14. My Provider and I have discussed a back-up plan if the technology fails to work during a session.

CLIENT CONSENT TO THE USE OF VIDEO THERAPY

By signing below, I indicate agreement to the following:

- I have read this Consent to Telehealth Services form and understand the risks and benefits of the use of Video Therapy in the course of my treatment.
- I hereby give my informed consent for the use of Video Therapy in my mental health care.
- I hereby authorize my Provider to use Video Therapy in the course of my diagnosis and/or treatment.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

Client (or Authorized Person) Signature **Date/Time**