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Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Crossroads Counseling Center professionals to connect with clients using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, education, and the transfer of clinical data.

I understand that I have rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse. Making expressed threats of violence toward self or others. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures through transmission. Crossroads Counseling Center utilizes secure, encrypted audio/video transmission software to deliver telehealth.

4. By signing this document, I agree to connect from an alternative location for the provision of audio-/video-/computer based psychotherapy services.

Payment for Telehealth Services

Crossroads Counseling Center will bill insurance for telehealth services when these services have been determined to be covered by the client's insurance plan.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone:

_____

_____

Client Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth. I have read this document carefully and understand the risks and benefits related to the use of telehealth services. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____ _____

Client's Signature Date

or

Parent/Guardian