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Teletherapy Informed Consent

With the advent of need-based therapy modalities due to distance, availability, and various health issues like the COVID-19 crisis, teletherapy has become an important substitute for in-person counseling. However, there are some concerns that are vital to understanding the limits of this new technology.

Please read all items below, and sign your assent that you understand; your clinician can go through any items during your first session.

1. I understand that my mental healthcare provider wishes to engage me in a telehealth consultation. I am also aware of the alternatives to telehealth therapy sessions, and am choosing to participate in this mode of therapy.
2. I acknowledge that video conferencing technology will be used to affect such a consultation, and that this session will not be the same as a direct visit due to not being in the same room as my provider. I also understand that I must have access to a functioning **webcam and microphone** on my computer, and that **mobile devices may not be functional** with our system.
3. Although my provider has ensured a HIPAA-compliant, secure, and private mode of videoconferencing, I understand that there are risks to any technology, including these online telehealth sessions. Those risks include but are not limited to:
    a. Network vulnerability at my home or other location at which I have chosen to receive online therapy.
    b. Potential interruption at my location by family, friends, or others, who would then gain access to my private conversation with the clinician.
    c. Technical difficulties that might interrupt a therapy session. In case of interruption, all reasonable efforts will be made to reestablish connection, and that I must be available by phone as well should other technology fail.
4. I understand that my provider will bill my insurance, much the same way in which he/she would bill an in-person visit. There may be difficulties in coverage, as this emergent modality is increasingly—but not perfectly—covered by insurers.
5. I agree to a method of payment for session fees (copays, etc.) as follows:
    a. I will read a credit card over the secure videoconference session to the provider, who will use the office card reader to process my payment before shredding my card number, OR
    b. I will leave and sign an authorization at the provider office to use a "card on file" for all payments related to telehealth.
6. If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority regarding mental health assistance on behalf of the patient.
7. I understand that, should an emergency situation arise during a telehealth session, there are limitations to the ability of the provider to offer emergency support due to distance. All reasonable efforts will be made to ensure client safety, including calling emergency services to client's location.

By signing below, I certify that I have read and understood these terms and policies, and that I will clarify any questions with my provider at the start of telehealth consultations.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____