Telehealth Consent

Version 1.0

I hereby consent to engage in distance therapy with my provider from 4KidHelp as part of my treatment. I understand that distance therapy includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to distance therapy:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to distance therapy. As such, I understand that the information disclosed by me during my therapy 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; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I understand that there are risks and consequences from distance therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. These risks are offset by my provider's use of a HIPAA-compliant service that is encrypted for video telehealth communications.

I understand that if my provider believes I would be better served by another form of mental health services (e.g. face-to-face services, group therapy), I will be referred to a provider who can provide such services in my area.

I understand that I may benefit from distance therapy, but that results cannot be guaranteed or assured.

Considerations:
It is important to note that there are limitations of distance therapy that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. We will both be able to review any concerns if distance therapy is not the best type of service for you.
3. Due to technology limitations, I may not hear all of what you are saying and may need to ask you to repeat things.
4. Technology might fail before or during the therapy session.
5. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.

6. If I am in crisis, I agree to call 911, go to my local emergency room, or call my local crisis center for help.
7. I am responsible for upholding the terms of my insurance coverage as defined by my contract with my insurance company.
8. I am aware of the privacy risks of using a public access computer or a shared network computer for this distance therapy.
9. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.