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Informed Consent Form for Telehealth

Technology Use and Confidentiality

Some clients may be obtaining services via telehealth. Telehealth includes the practice of therapy delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Because of recent advances in communication technology, the field of telehealth therapy has evolved significantly, and research has indicated that telehealth therapy is an effective means of receiving therapy. However, be aware that an important aspect of therapy is sitting face-to-face with an individual, such that non-verbal communication (body signals) is readily available to both therapist and client. Without this information, telehealth therapy may be slower to progress or be less effective than in-person therapy. It is important that clients understand that telehealth services may or may not be as effective as in-person therapy; therefore, close attention will be given to a client's progress by periodic evaluation of the effectiveness of this form of therapy. If the therapist believes a client would be better served by another form of therapeutic services (e.g. face-to-face services) the client will be referred to a therapist who can provide such services.

Telehealth services enable clients to receive services where physical services are not an option. However, as with any medical procedure, there are potential risks associated with the use of telehealth including but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that: the process of providing therapy via telehealth services could be disrupted or distorted by technological failures; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. If a client is located in a country in which security is a prime concern, then that information needs to be communicated so any other security measures can be included if needed.

I Understand that I have the Following Rights with Respect to Telehealth:

(1) 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.

(2) 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; 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 telehealth interaction to other entities shall not occur without my written consent.

(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 therapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of intervention (e.g. face-to-face services), I will be referred to a mental health professional who

can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telehealth therapy, but that results cannot be guaranteed or assured.

(4) I understand that use of the VSee Telehealth software may at times have issues with wifi connectivity. All attempts to keep information confidential while using this system will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with communication systems. Signing this form shows an awareness of these issues and a decision by this client to use this system for video conferencing. I will not hold this therapist liable for any gathering or use of client information by these service providers.

(5) I understand that I have a right to access my personal information and copies of case records in accordance with Illinois law. I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

(6) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based therapy services. If I am in crisis or in an emergency I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. By signing this document I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations (see or hear things others don't, if I have delusions=beliefs others may consider unrealistic), if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

Patient Consent to the Use of Telehealth Mental Health Services

I have read and understand the information provided above, have discussed any questions with my therapist, and all of my questions have been answered to my satisfaction. Regarding the use of telehealth services, I understand that the clinician will use their best efforts to conceal personal information and abide by HIPAA/PHI standards and I will use my best efforts to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information. I hereby give my informed consent to engaging in telehealth mental health services.

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Signature of Patient/Client Date

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Signature of Parent, Guardian or Personal Representative* Date

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*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ Patient/Client refuses to acknowledge receipt:

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Signature of Therapist