Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Living Well Christian Family Clinic mental health professionals to connect with clients using interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resource, education, and the transfer of medical and clinical data.

I understand that I have the 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 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 toward an ascertainable victim; and where I make statements about my mental or emotional state that could potentially result in harm to myself. 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 with regard to 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, that despite reasonable efforts on the part of the counselor, 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 electronic storage of my personal information could by unintentionally lost or accessed by unauthorized persons. Clinic for Christian Counseling utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my counselor believes I would be better served by face-to-face services, I will return to office visits. Additionally, I understand that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse. I will be open to referral to more intensive services, should that be required.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my counselor in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultations and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and /or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.
9. I understand that I have a right to access my medication information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
10. By singing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. I f 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.

Payment for Telehealth Services

Living Well Christian Family Clinic will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. These fees will be billed at the same rate as in-person sessions. If insurance does not cover telehealth, the client is responsible for the payment of therapy fees. If this is a hardship, client may wish to contact the therapist to discuss payment plans and options.

We cannot guarantee payment from your insurance company. To avoid disappointment, we strongly suggest that clients contact their insurance company to make certain that their mental health insurance assumptions regarding telehealth are correct.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. 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, I understand, and I agree to the terms of this document.

_____ _____

Printed Name of Client Client DOB:

_____ _____

Client Signature Date

_____ _____

Parent/Guardian Signature Date

LIVING WELL CHRISTIAN FAMILY CLINIC

CONFIDENTIAL CONTACT FORM

Name: _____

Please indicate the method(s) **with which you would like us to contact you** and list the corresponding numbers or addresses where indicated.

Please choose **one primary means** for contact and **one means for appointment reminders** by checking the box.

		Primary Means- indicate one:	Appointment Reminders- indicate one:
Home Phone	_____	☐	☐
Cell Phone	_____	☐	☐
Work Phone	_____	☐	☐
E-mail	_____	☐	
Other	_____	☐	
Mailing Address	_____		
	_____		

Please describe any **restrictions** on the means and/or location you want us to use (e.g.- do not leave a message on home telephone number):

If you would **NOT** like to receive appointment reminders, please indicate here: ☐

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual (e.g.- minor child), complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Print **Email Submit**

Please refer to LWCFC Privacy Practice Notice for more information on confidential communication and HIPAA
03/20