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Forensic Coordinator
Phone: 302-450-6441

Telehealth Informed Consent

1. I, _________________________________, understand that telehealth services are completely voluntary and I can end the session at any time.

2. I understand that none of the telehealth sessions will be recorded.

3. I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

4. I understand that telehealth is performed over a secure communication system that is HIPPA compliant. I accept the risk that a technological breach could affect confidentiality.

5. My therapist has explained to me how video conferencing technology procedures will be used. I understand that any telehealth sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.

6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions if it is felt that the videoconferencing is not adequate for my situation.

7. I understand that I may experience benefits from the use of telehealth, but that no results can be guaranteed or assured.

8. I understand that if the video conferencing connection drops while I am in a session and I cannot reconnect, I should contact the office of Atlantic Psych Associates to establish a secondary method of contact or to reschedule my appointment.
9. I understand that this form is signed in addition to the Information, Authorization, and Consent to Treatment document and that all other policy and procedure documents I have completed apply to telehealth services.

10. I understand that I am still responsible for any co-pays or deductibles for my session, and that they will be charged to the credit card I have on file at the time of the appointment.

11. I understand that I am responsible to make sure that telehealth is a covered benefit under my insurance. I understand that I am responsible for payment if my insurance will not cover the session.

12. I understand that Atlantic Psych Associates is not liable for any breaches in privacy or confidentiality that is due to problems based from the electronic device used by me or by my location. Some applications specifically interact via phone / tablet, device, etc. and have the capability to report activity, gps location, etc. This also includes others overhearing you at your location, others using your electronics, or by stolen or hacked electronics.

13. I understand that I am responsible for providing the necessary telecommunications equipment and internet access for my telehealth sessions, the security on my computer, and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.

14. I understand I have the right to withhold or withdraw this consent at any time.

15. I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment documents that I have previously signed.

____ _________________
Signature of client or guardian Date

____ _________________________________
Printed name of client or guardian Name of client (if signed by guardian)

I would like my link to my telehealth session to be sent via (pick one):

-email (for computer or mobile phone videochat) _______________________________________
E-mail address

-text message (for mobile phone videochat only) _______________________________________
Phone number