**Informed Consent for Telehealth Services**

**Telehealth Definition**

Telehealth is the provision of healthcare remotely by means of telecommunications technology. Technology includes, but is not limited to, telephone, video, internet, smartphone, tablet, computer, or other electronic means. Counseling or therapy provided via telehealth includes the practice of psychological healthcare consultation, delivery, diagnosis, education, referral to resources, and the transfer of medical and clinical information.

**Client Rights with Respect to Telehealth**

* The laws that protect the confidentiality of personal information, including HIPAA regulations, apply to telehealth. This means information disclosed during session is confidential. All communication is confidential with the following limitations and/or exceptions:
	+ It is determined you are a danger to yourself or someone else
	+ You disclose abuse/neglect/exploitations of a child, elderly, or disabled person
	+ You disclose inappropriate behavior by another mental health professional
	+ A court orders the disclosure of client information
	+ You direct us to release your records to another professional, at which time a “Release of Information” form would need to be completed and signed
	+ We are otherwise required by law to disclose information
* Consent to telemental health therapy is required to proceed with treatment, even if a previous consent for in-office treatment has been agreed upon. An emergency management plan and, if needed, safety plan must also be in place. Consent for telemental health may be withdrawn or withheld at any time, without affecting the right to future care or alternative modes of treatment. Access to medical records may be requested at any time. Telemental health sessions are not ever recorded and would require additional consent to be recorded.
* If at any point the counselor or therapist feels that another form of intervention is more appropriate, an appropriate referral will be made.
* By agreeing to participate in telehealth, I agree to participate in the use of HIPAA compliant, secure, encrypted video conferencing via TheraNest electronic health record. This means that the client and counselor/therapist must be able to access a computer with video and audio teleconferencing capabilities, internet, and a confidential place to meet without interruption.
* It is understood that there are risks and consequences of telehealth, including, but not limited to the possibility, despite counselor/therapist reasonable efforts, that:
	+ The transmission of personal information could be disrupted or distorted due to technical failures
	+ The transmission of personal information could be interrupted by unauthorized persons
	+ The electronic storage of personal information could be unintentionally lost or accessed by unauthorized persons
* Certain situations, including emergencies and crises, are inappropriate for telemental health therapy services. If in an emergency or crisis, 9-1-1 will be called or help will be sought from a hospital or crisis-oriented health care facility in my immediate area.
* E-mail is not a secure means of communication and may compromise your confidentiality, however, we realize that many prefer this method of communication to quickly convey information. It is strongly suggested that you communicate through the secure messaging system within TheraNest to communicate therapeutic information with you counselor or therapist. This is not an appropriate method of communication when in crisis.
* Additional requirements of telemental health include:
	+ Being properly dressed for telehealth sessions, as if you were in the office, including wearing both shirt and pants at all times.
	+ No driving or other work distractions during telehealth sessions. You must be at a physical address where you can be located if needed.
	+ No drinking alcohol or smoking during session.

**Structure, Cost, and Cancellation Policies for Telemental Health Services**

Fees for telemental health sessions are the same as in-office appointments. The fee for each session is $75.00 and must be paid at the beginning of session. Counseling sessions will last for approximately 50 minutes for adults and 30 to 50 minutes for minors based on attention span and time needed to communicate with parents prior to or after the session. For sessions with minors, a parent is required to be present at the initiation and conclusion of session for 5-10 minutes to ensure technology is properly in use, for check-ins regarding client, and for safety planning, unless otherwise planned with counselor or therapist.

Please inform your counselor or therapist of your means of payment at the start of session. Digital payments may be submitted online by visiting <https://onrealm.org/fbw/-/give/beacon>.  When you reach this site enter the amount due, date of session, then enter your e-mail address and follow the remaining steps for payment processing. You will need to create a Realm account, which will allow for confidential records of payment to be kept.

If you are not able to submit payment online, you may pay by cash or check by mailing your payment directly to First Baptist Wylie at 100 N. First Street Wylie, TX 75098. Please make sure to include a note designating payment to Beacon Counseling and your counselor or therapist.

We expect you will provide notice 24 hours in advance of a cancellation of telemental health session. If appropriate notice is not given, then you will be charged the full session rate for the missed session, due prior to the start of your next session. The practice of being charged for non-attendance and late cancellations is standard in the field, respecting the counselor’s time availability that cannot be offered to another on short notice. Emergency cancellations will be considered on a case-by-case basis by your counselor. Please understand that the missed appointment fee will be invoiced and mailed to your address on file if not returning to treatment.

**Client Consent to the Use of Telehealth**

I have read and understand the information provided above regarding telehealth. I have discussed this information with my counselor or therapist and all of my questions have been answered to my satisfaction. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

By my signature below, I hereby state that I have read this document carefully, understand the risks and benefits related to the use of telehealth services, and agree to the terms of this document so that I may participate in telehealth services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Client’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Client’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent or Guardian Signature *(If Needed)*  Date