Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, Central Ohio Counseling providers, as part of my psychotherapy and/or medication management. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. I understand that Central Ohio Counseling providers will only use a HIPAA compliant telehealth platform to conduct telemental health appointments.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that I must use a computer, tablet, or smartphone that has both a camera and audio functions so that we are able to see and hear one another. I also understand that I must choose a quiet place, free of distractions and other people to conduct our telemental health appointments. At no time will these appointments be held in a public place or setting. I also understand that I should use a private, secure Wi-Fi network to conduct appointments, public Wi-Fi networks are not recommended.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 614-785-1115 option 2 to discuss since we may have to re-schedule.

7) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

Emergency Protocol

You agree to inform me of the address where you are at the beginning of each visit. I also must keep on file an emergency contact. Your emergency contact will only be used in a life-threatening emergency. My emergency contact is:

Name_____ Relationship_____

Phone_____ Alternate phone_____

I have read the information provided above and discussed it with my provider. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Printed Name of Client Signature of Client

_____

Date