family service

counseling • support • compassion

CONSENT FOR TELEHEALTH OR TELEPHONE MENTAL HEALTH SERVICES

By signing this form, I understand and agree with the following:

1. Telehealth is the delivery of services using interactive technologies (audio, video, or other electronic communication) between a practitioner and a client/patient who are not in the same physical location.

2. The interactive technologies used in Telehealth services incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel.

3. The laws that protect the privacy and confidentiality of health, mental health and other services also apply to telehealth sessions and tele-intervention. Information obtained during a telehealth session or meeting that identifies me or my child will not be given to anyone outside of Family Service without my consent except what is necessary for necessary for establishing my care, maintaining treatment records, performing billing, securing payment, and performing other administrative healthcare operations.

4. There are both mandatory and permissive exceptions to confidentiality, including, but not limited to, the reporting of child, elder, and dependent adult abuse, expressed threats of violence toward an ascertainable victim; and/or expressed threats of suicide or threat of other serious forms of self-harm.

5. Any electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

6. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery following HIPAA compliance laws.

7. I understand that Family Service will take all necessary precautions to protect my privacy and confidentiality but I also understand that there is a slight risk of a security breach with any internet-based communication. However, I believe that the potential benefits of telehealth outweigh this risk.

8. I understand, agree and accept responsibility for protecting my personal safety and the confidentiality of my Telehealth sessions by placing myself in a safe, private, comfortable environment for my telehealth sessions, free from distractions and sufficiently distant from others who are not explicitly invited into in my Telehealth sessions.

9. I agree to participate in Telehealth services only when I am using a secure internet connection.

10. I understand that my email address is required for audio-visual services, and I will keep Family Service informed of any change to my email address.

11. I understand that I have the right to withhold or withdraw my consent to the use of telehealth at any time. Withdrawing my consent will not affect my eligibility to receive future services.

12. This service is provided by various technology platforms (including but not limited to video, phone, and email) and may not involve direct face-to-face communication. I acknowledge that there are benefits and limitations to this type of service.

13. My practitioner and I will regularly reassess the appropriateness of continuing my service delivery through the use of the technologies we have agreed upon today and my practitioner will suggest modification or change to the service delivery plan as needed.

14. I acknowledge that appointment confirmations, appointment changes or other important communications with Family Service will be conducted through the telephone. I agree to check my telephone voicemail regularly. I further understand that all Telehealth invitations for my sessions will come through the email address I provided to Family Service and telehealth sessions will take place using a HIPAA compliant **Zoom Healthcare** and/or HIPAA compliant **Microsoft Teams** platform.

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

I hereby consent to the use of Telehealth by Family Service.

Name of Client: _____

Name of Parent/Guardian: _____

Client/Parent/Guardian Signature: _____

Date: _____