



Telehealth Informed Consent Form

1. Definition of Services

Telehealth involves the use of electronic communications (video, phone, or secure messaging) to enable healthcare providers at different locations to share individual patient medical data for the purpose of improving patient care. The electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard data against intentional or unintentional corruption.

2. Expected Benefits

- Improved access to care by enabling a patient to remain in their home or office.
- More efficient evaluation and management.
- Reduced travel time and associated costs.

3. Potential Risks

While telehealth is highly effective, there are potential risks unique to technology, including:

- **Technical Failures:** Interruptions, unauthorized access, or technical difficulties could occur.
- **Security Breaches:** Despite high-level encryption, there is a very remote risk that electronic communications could be compromised.
- **Limited Assessment:** The therapist may not be able to provide certain types of clinical observations that are possible in person.

4. Confidentiality & Security

- All laws and professional standards that protect the confidentiality of your health information also apply to telehealth.
- You are responsible for ensuring a private, quiet, and secure environment for your sessions.
- Sessions will not be recorded by the provider without your written consent. Similarly, you agree not to record any sessions without the provider's written consent.



5. Patient Responsibilities

- You must use a secure internet connection (rather than public Wi-Fi).
- You must provide your current physical location at the beginning of every session.
- You must provide a backup phone number where you can be reached if the video connection fails.

6. Emergency Protocol

In the event of a mental health emergency or a technological breakdown during a crisis, telehealth may not be appropriate.

- If you are in immediate danger: Please call 911 (or your local emergency number) or go to the nearest emergency room.
- Emergency Contact: _____ (Name/Phone)

7. Fees

The same fee structure and cancellation policy apply to telehealth as to in-person visits.

8. Consent to Treatment

By signing this form, I certify:

1. I have read and understand the information provided above.
2. I have had the opportunity to ask questions about telehealth services.
3. I understand that I have the right to withdraw my consent at any time without affecting my right to future care or treatment.

Patient Name (Printed):

Patient/Guardian Signature:

Date: