
***Insight and Empowerment, LLC***
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## Telemental Health Informed Consent

**Client Name:** _____ **Date:** _____

**Email address:** _____ **Phone:**_____

I understand and agree to the following with respect to medical/mental health services:

I, _____, hereby consent to participate in telemental health with, Insight and Empowerment, LLC as part of my psychotherapy. 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 located in two different locations. I understand the following with respect to telemental health:

1) Privacy and confidentiality are shared responsibilities of the provider and the client. It is my responsibility to maintain privacy on the client end of communication. I agree to use reasonable security protocols to protect the privacy of my own health care information. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

2) 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.

3) I understand that it is my responsibility to check with my insurance plan to determine coverage of telehealth services.

4) 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.

5) 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.

6) 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).

7) In addition, I understand that telehealth services and care may not yield the same results nor be as effective as face to-face service. I understand that if my provider believes I would be better served by another form of psychotherapeutic service (e.g. in-person), I will be referred to a provider in my area who can provide such service. My provider and I will regularly reassess the appropriateness of continuing to deliver services to me using the technologies we have agreed upon today, and modify our plan as needed.

8) 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. Furthermore, if I believe I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth, instead I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.

9) 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 discuss since we may reconnect within ten minutes, please call me at (208) 932-7048 to discuss since we may have to re-schedule.

10) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**Emergency Protocols**

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____
and my emergency contact person's name, address, phone:
_____
_____

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

**Client's Signature:** _____

Date: _____

**Parent/Guardian Signature:**_____

Date: _____