Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental health therapy. This document covers your rights, risks and benefits associated with receiving TeleMental Health services. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined: TeleMental health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. Synchronous (at the same time) video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services: While TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, therapist might not see various details such as facial expressions. Or, if audio quality is lacking, therapist might not hear differences in your tone of voice that could be easily picked up if you were in the office. Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. The therapist will take every precaution to ensure a technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. Consider using a “do not disturb” sign/note on the door. The virtual sessions must be conducted on a Wi-Fi connection for the best connection and to minimize disruption.

In Case of Technology Failure: I understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call your therapist at the number provided for you by the therapist. Please make sure you have a phone with you, and therapist has that phone number. We may also reschedule if there are problems with connectivity.

I _____ *[name of patient(s)]* hereby consent to engaging in TeleMental health with a U.S.VETS Clinical Program Service Provider, for supportive services (Therapy, Case Management, or other referral services). I also consent to receiving these services from a Licensed Provider or an unlicensed clinical intern, who is under the supervision of a Licensed Provider, as applicable. I understand that “TeleMental health” includes the practice of health care delivery,

diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. I understand that TeleMental health may also involve the communication of my medical/mental health information, both orally and visually, to Health Care practitioners located in California or outside of California, as allowed by the law.

I understand that I have the following rights with respect to TeleMental health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to TeleMental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

In case of emergency my location is:

_____

and contact information for local emergency individual is:

_____

I understand that the therapist may contact my emergency contact and/or appropriate authorities in case of emergency. I also understand that the dissemination of any personally identifiable images or information from the TeleMental health interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from TeleMental health, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies. In addition, I understand that TeleMental health-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will switch to utilizing the services that are recommended as more effective. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not be improved, and in some cases may even get worse.

(4) I understand that I may benefit from TeleMental health, but that results cannot be guaranteed or assured.

(5) I understand that I have the right to access my medical and mental health information and copies of medical records in accordance with California law.

(6) I understand that I will be asked to complete and sign more expansive U.S.VETS Intake Documents, when I am able to meet with my Therapist or Service Provider face to face. I agree to complete these documents, immediately, once in-office sessions may resume.

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

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Client's name (please print)

_____ _____

Signature of patient/parent/guardian/conservator Date

_____

Therapist's name (and License Number, as applicable)

_____ _____

Signature of Therapist Date

_____

Supervising Therapist's name and License Number

_____ _____

Signature of Supervising Therapist Date