A New Tomorrow
Behavioral Health Services

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TELEHEALTH INFORMED CONSENT FORM

I understand and agree to receive telehealth services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telehealth, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telehealth is not an appropriate method of treatment for me.

I recognize the benefits of telehealth, which may include the following: 1) reduced cost and time commitment for treatment due to the elimination of travel; 2) ability to receive services near my home or from my home; and 3) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my sessions is prohibited.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this. I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participate in tele health under the conditions described in this document.

Client's Name (Print):____

Legal Guardian (if application-Print): ______________________________

Signature of Client or Responsible Party:____________________________

Date:__________________________