Informed Consent Addendum for Telehealth Services

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Client Name

DEFINITION OF TELEHEALTH SERVICES

Telehealth involves the use of electronic communication including interactive audio, video, and/or data communication to enable clinicians, healthcare providers, and specialists to consult, diagnose, treat, educate, and deliver counseling and other healthcare services from a distant location.

BENEFITS & RISKS OF TELEHEALTH

Participation in telehealth services has both benefits and risks. A primary benefit of telehealth services is improved access to counseling and services by enabling a client to remain in his/her home or work. This can make treatment more comfortable and convenient, reduce travel, reduce need for childcare, and reduce a client's time from work or school. Similarly, telehealth makes services more accessible for those who struggle to leave their homes or who reside in rural areas where there is a health services provider shortage. Sometimes, people feel more comfortable in their own environment rather than in a clinician's office.

As with any counseling, there are potential risks associated with the use of telehealth. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Still, failures or deficiencies of equipment can result in delay of evaluation and treatment, and in rare cases, security protocols could fail, causing a breach of privacy of personal medical information. Of course, nothing replaces face-to-face contact between a client and a therapist.

CONFIDENTIALITY

The laws that protect privacy and the confidentiality of medical information for in-person counseling also apply to telehealth. Any information disclosed by the client during the course of therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence that the client may make towards a reasonably identifiable person. The client also understands that if he/she is in such mental or emotional condition to be a danger to self or others, the therapist has the right to break confidentiality to prevent the threatened danger. In addition, the client is solely responsible for the confidentiality of his/her own environment during a telehealth appointment.

MENTAL HEALTH EMERGENCIES

If at any time telehealth does not feel like sufficient support, please inform us, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. If you have a mental health emergency, we urge you **NOT** to wait for a call back, but to do one or more of the following:

- Call or text 911
- Go to your nearest emergency room
- Call the Suicide Prevention Lifeline at 1-800-273-TALK (8255)
- Use the Crisis Text Line by texting 'HELP' to 741-741

CONSENT

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.

I understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons.

Please initial that you have read this page (for couples, two sets of initials are required) ________

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I understand that telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I understand that the clinician will be at a different location from me. I understand that the clinician is licensed in the states of Montana and Oregon, and therefore, practices under the laws of Montana and Oregon.

I understand that my clinician from a distant location will:

- Ensure my identity by requiring me to provide proof of my identity (i.e., driver's license).
- Require me to provide my location at the time of the encounter including my physical address and telephone number.

I understand that telehealth is not appropriate for all individuals and that my clinician may request that I visit him/her in person to further evaluate my condition. I further understand and agree that I will seek in-person psychotherapy and/or emergency psychiatric care with a licensed provider should I experience psychiatric issues that are not stable.

MY PHYSICAL ADDRESS DURING TELEHEALTH SESSIONS

Physical Address:_____________________________________ City:____________________ State:_______ Zip:______________

MY EMERGENCY CONTACT WITHIN 30 MILES OF MY LOCATION

Name: (Last) ___________________________ (First) _____________________ Release Signed? ☐

Address:_____________________________________ City:____________________ State:_______ Zip:______________

Cell #: ______________________ Home #: _______________________ Work #: _____________________

Relationship: Spouse ☐ Parent/Legal Guardian ☐ Other ☐ *specify*_______________________

EMERGENCY SERVICES IN MY AREA

Facility Name: ____

Address:_____________________________________ City:____________________ State:_______ Zip:_____________

Business #: ______________________

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. Please sign and date below indicating that you understand the contents of this form, that you agree to the policies of your telehealth relationship with us, and that you consent to the telehealth services of Infinite Hope Counseling LLC.

____ __________________
Client Signature Date

____ __________________
Parent/Legal Guardian Signature *mandatory if client is a minor* Date

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