

INFORMED CONSENT FOR TELEHEALTH TREATMENT**Benefits and Risks of Telehealth.**

Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. Our communications will take place using our HIPAA compliant electronic medical records platform. This is the same medical records system we have already been using in the office. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the patient or clinician is unable to continue or meet in person. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of telehealth, there are some differences between in-person psychotherapy and telehealth, as well as some risks:

Risks to confidentiality. Telehealth sessions may take place outside of the clinician's private office, which increases the potential for other people to overhear sessions if you are not in a private place during the session. The clinician will take reasonable steps on their end to ensure your privacy, but it is important for you to protect your privacy by finding a private place for the session where you will not be interrupted. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. The clinician will not engage in telehealth with patients who are in a crisis situation requiring high levels of support or intervention. If an emergency crisis arises during the course of our telehealth work, we will call authorities and provide them with your last known location, as well as your home address. If our session is interrupted for any reason, and you are having an emergency, do not call your clinician; instead, call 911 or go to your nearest emergency room. Contact your clinician after you have called or obtained emergency services. If the session is interrupted and you are not having an emergency, wait for your clinician to contact you via phone. You can always call the office at 248-572-7002 to speak with our office staff.

Communications and Confidentiality

For communications between sessions, our therapists use HIPAA compliant email or text messaging (with your permission) which are limited to scheduling matters, unless we have made another agreement. If you have billing questions, contact our office at 248-572-7002. Please be aware that we cannot guarantee the confidentiality of any information communicated by email or text. Our clinicians will also not discuss any clinical information by email or text. Clinicians have a legal and ethical responsibility to make their best efforts to protect all communication that are a part of telehealth and do NOT record sessions. However, the nature of electronic communication technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communication.

Fees

The same fee rates will apply for telehealth services as for in-person psychotherapy. As with in-person appointments, it is not guaranteed that your insurance will cover sessions, making any fees solely your responsibility. Please contact your insurance company prior to engaging in telehealth to determine whether your session will be covered. **Please provide 24 hour notice of appointment cancellation to avoid a \$50 fee.**

- I will be responsible for any charges not covered by insurance, including co-payments and deductibles.
- My Credit Card on File will be used to cover the charges stated above.

I have read, understand and agree to all the above, have had an opportunity to ask questions about this information, and I consent to evaluation and treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Patient (Parent or Guardian) Signature _____ Date _____