# THE THERAPY PLACE

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## TELEMENTAL HEALTH INFORMED CONSENT

*Definition of Tele-mental Health Services*: Tele-mental Health Services is the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the client and the therapist, for the purpose of diagnosis, consultation, and/or treatment. We feel it is important that, as our client, you are fully informed about the therapy services you will be receiving. Your signature below indicates that you have read and understand the practice policies of this therapy in helping you make an informed decision about entering tele-mental health therapy.

1. I understand the same rights to confidentiality and limits to confidentiality that apply in face-to-face sessions also apply to tele-mental health therapy. I understand that, due to legal or ethical obligation, specific circumstances may require my therapist(s) to break confidentiality and report information obtained as a result of the therapy process. Those circumstances exist when: a) Therapist believes a client may be a danger to him or herself or to others; b) Therapist believes that a child, elderly or disabled person may be subject to abuse or neglect; and/or c) a court order exists that information regarding the therapy process be provided. I understand that any such breaches of my right to confidentiality will be discussed with the therapist's clinical supervisor(s).

2. I understand that tele-mental therapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

3. I understand that I am responsible for (1) providing the equipment and internet access for my tele-mental health therapy sessions, (2) the security of my electronic device, and (3) arranging a location with sufficient privacy that is free from distractions or intrusions for my therapy session(s).

4. I understand that there are potential benefits to participating in tele-mental health therapy sessions, but that no results can be guaranteed or assured. Despite my efforts and the efforts of my therapist, my condition may not improve.

5. I understand that there are potential risks to participating in tele-mental health. I understand my therapist utilizes secure audio/video transmission software to deliver tele-mental health services. However, risks might still include unintended breaches of confidentiality such that the transmission of my personal information could be interrupted by unintended, unauthorized, third persons.

6. Despite reasonable efforts on the part of the therapist, therapy sessions may be disrupted or distorted by technical failures or difficulties.

7. I understand that if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services), I will be asked to attend in-person sessions, or I may be referred to another mental health professional.

My signature below indicates that I understand and agree to the above terms and give my full and informed consent to receive tele-mental health services.

_____ _____

Client Signature Date Client Signature Date