1381 Crossings Centre Drive, Suite E
Forest VA 24551
Phone 434-219-5621 Fax 434-305-1072

Client Name: _____

Date: _____

Date of Birth: _____

Telehealth Informed Consent Form

Definition of Telehealth:
Telehealth involves the use of electronic communications to enable Empower Counseling, PCs' mental health professionals to connect with individuals using HIPAA compliant interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of the client.

By signing this form, I understand the following:
I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to any other entities without my written consent.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future treatment.

I understand that telehealth may involve electronic communication of my personal medical information.

I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to- face” psychotherapy.

I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

I understand that it is the client’s responsibility to secure a confidential private location while meeting with my counselor through Telehealth appointments. There are limitations to confidentiality based on client’s environment during appointment.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

I understand that Telehealth is being offered as a temporary measure to provide a continuum of care during the current state of emergency in Virginia. Telehealth can be discontinued at any time based on my counselor’s discretion.

By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

Empower Counseling, PC will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. In the event that insurance does not cover telehealth, the individual can opt to pay out of pocket. Co-pays/ payments will be obtained at time of service. We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.
By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____
Client (Print Name)

_____
Client's Signature Date

_____
Parent or Guardian Signature Date

Please return this form by fax at 434-305-1072 or email directly to your counselor. Email consents or photographs of this form are permitted.

Please call the office prior to your session to make payment for your telehealth service at 434-219-5621.