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Telehealth Informed Consent Policy

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for, diagnosis, consultation, treatment therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote monitoring are all considered telehealth services.

I, _____, hereby consent to participate in telemental

health (counseling) with, **J. Patrick Meagher**. I understand that telemental health is the practice of delivering clinical health care services (counseling) via technology assisted media or other electronic means between a practitioner and a client who are physically present in two different locations.

I understand the following with respect to telehealth:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, health insurance or EAP benefits to which I would otherwise be eligible.
2) I understand there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those session is confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHP) also apply to telemental health unless an exception to confidentiality applies (I.e. mandatory reporting of child, elder, or vulnerable adult abuse, danger to self or others.
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
7) I understand that telemental health billing information is collected in the same manner as a regular office visit. Please refer to the Professional Counseling Services Policy Agreement for further information.

Emergency Protocol

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may call on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the case of an emergency.

In case of an emergency, my location is:

_____

_____

_____

Name of Emergency Contact Person—perhaps a relative, spouse, significant other, or friend:

_____

Contact Person's Relationship to you _____

_____

Telephone number of Emergency Contact Person _____

I have read the information provided on this form and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of J. Patrick Meagher Date