Barrington Center for Counseling and Psychotherapy

901 Fox Glen Court
Barrington, IL 60010
Phone: (847) 304-0780
Fax: (847) 304-0795

INFORMED CONSENT FOR TELEHEALTH SERVICES

I _____, (name of patient) consent to participate in telemental health services as part of my psychotherapy. I understand that telemental health services is the practice of delivering clinical health care via technology assisted media or other electronic means between a therapist and patient who are located in different two locations.

Prior to starting telehealth services, I understand the following with respect to telemental health services:

1. I understand that I have the right to withdraw consent at any time without affecting my rights to future care or services, and I, or my therapist, can discontinue telemental health services if this type of service does not benefit my needs.

2. I understand that there are risks and consequences associated with telemental health services, including but not limited to, disruption by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I understand that I am responsible for information security on my computer or cell phone and in my own physical location, and that I am responsible to ensure privacy at my own location.

4. I understand that there will be no recording of any online or phone sessions by either party. All information disclosed within the session and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

5. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) 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, or court order).

6. I understand that if I am in imminent risk of harm to myself or others or experiencing a mental health crisis that cannot be resolved remotely, that my therapist may need to contact my emergency contact and/or appropriate authorities and a higher level of care may be needed.

    - In the event of a life-threatening/mental health crisis, my location is:

      _____

    - and my emergency contact person's name, address and phone number are:

      _____

7. I understand that it is my responsibility to verify my insurance coverage for telemental health services, and that I am responsible for full payment of services in the event that insurance does not pay.

8. I understand that it is my responsibility to notify my therapist in advance if I need to cancel or change my telehealth appointment or I will be charged for a late cancelled/missed appointment.

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9. I understand that technical difficulties may result in service interruptions, and that my therapist cannot guarantee that services will be available or work as expected. If a service interruption occurs, I can be reached at the following number: _____ to restart the session, when possible, or to reschedule.

* I have read and understand the information provided above regarding telemental health services. I have discussed it with my therapist and my questions have been answered to my satisfaction.

_____ _____

Patient Signature (including patients 12-17 yrs old) Date:

_____ _____

Parent/Legal Guardian Signature Date:

_____ _____

Therapist Signature Date: