***Mindsolutions.LLC***

***TELEHEALTH CONSENT FORM***

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to engage in Telehealth with\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Therapist).

I understand that Telehealth is a mode of delivering health care services, including

psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis,

consultation, treatment, education, care management, and self-management of a patient’s

health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications

via Telehealth under the same laws that protect the confidentiality of my treatment

information during in-person psychotherapy. The same mandatory and permissive

exceptions to confidentiality outlined in the [Informed Consent Form or Statement of

Disclosures] I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but

not limited to, the possibility, despite reasonable efforts and safeguards on the part of my

therapist, that my psychotherapy sessions and transmission of my treatment information

could be disrupted or distorted by technical failures and/or interrupted or accessed by

unauthorized persons, and that the electronic storage of my treatment information could

be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via

Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am

responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to

verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same

results as in-person therapy. I understand that if my therapist believes I would be better

served by in-person therapy, my therapist will discuss this with me and refer me to

in-person services as needed. If such services are not possible because of distance or

hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range

of mental and emotional issues, there is no guarantee that Telehealth is effective for all

individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot

be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that

neither I nor my therapist may record the sessions without the other party’s written

permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for

insurance patients: I have discussed with my therapist and agree that my therapist will bill

my insurance plan for Telehealth and that I will be billed for any portion that is the patient’s

responsibility (e.g. co-payments)], and I have been provided with this information in the

[Informed Consent Form or Name of Payment Agreement Form].

10. I understand that my therapist will make reasonable efforts to ascertain and provide me

with emergency resources in my geographic area. I further understand that my therapist

may not be able to assist me in an emergency situation. If I require emergency care, I

understand that I may call 911 or proceed to the nearest hospital emergency room for

immediate assistance.

I have read and understand the information provided above, have discussed it with my

therapist, and understand that I have the right to have all my questions regarding this

information answered to my satisfaction.

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Patient’s Signature Date

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Patient’s Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to

the above advisements, and Patient has verbally consented to receiving psychotherapy services

from Therapist via Telehealth.

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Therapist’s Signature Date.