My Mental Health, LLC

Telehealth Therapy Consent Form

1. I understand that my psychotherapist has offered me tele-psychotherapy.
2. My provider has discussed the video conferencing technology that will be used for tele-psychotherapy, and how it is not the same as in office, direct client/therapist.
3. I understand that tele-psychotherapy has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I also understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. My provider and I have discussed our mutual obligation to be in a private place for our tele-psych sessions, with minimal distractions/ chance for interruption, optimal internet/ phone connection and reception, sufficient charge on equipment, and the importance of using a HIPPA compliant and secure interface to maintain confidentiality for our sessions.
5. I understand that the tele-psychotherapy sessions will not be recorded or saved in any way. Any record of the visit will be kept as a progress note in the same EMR (Electronic Medical Record) just as it would be for an office based visit.
6. I have provided my provider with up to date emergency contact information. And I understand that in the event of concerns for my safety or welfare, or for the safety or welfare of others, my provider will call on my emergency contact to assist. I recognize this is one of the major limitations of tele-psychotherapy where I am not in the office with my provider for them to be able to intervene in urgent situations more "hands on."
7. I understand that Tele-Psychotherapy adheres to all MMH office policies including the need to schedule care in advance through the front desk staff, to use the office phone number for any needs in between visits, and that I am not to expect my therapist to be available outside of scheduled care. I agree to the normal late cancellation/ no show policies. And that if I am more than 15 minutes late for the scheduled tele-psychotherapy session, this will count as a no-show and I will be billed the standard $75 no show rate. If there are technological difficulties that interfere with completing the session, I understand the provider will only bill at a prorated amount.
8. I understand that my therapist or I can choose to discontinue the tele-psychotherapy at any time, including if it is felt that the videoconferencing connections are not adequate for the situation, or if its felt that office based care is more appropriate.
9. I understand that video/ face to face technology (as opposed to voice alone) is required by most insurance carriers to reimburse for tele-psychotherapy. And that most insurances will cover tele-psychotherapy at least in the short term when it does not exceed 25% of the total psychotherapy based care. I understand that I am responsible for verifying that my particular insurance policy will cover the Tele-Psychotherapy sessions, especially if this is to be more than 25% or short term use only. I accept full financial responsibility for payment in the event that insurance does not cover Tele-Psychotherapy sessions.
10. I recognize that in general, tele-psychotherapy is a short term alternative to office based care. That it is not intended for emergency care. In the event of an emergency, I know that I should call 911, Crisis Response, or proceed to the nearest Emergency Department.

By signing this form, I certify:

- I have read or had this form fully explained to me.
- I fully understand its contents including the risks and benefits of Tele-Psychotherapy.
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: ______________________________ **Date:** ________________

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