FAMILY ASSOCIATES OF MERRIMACK VALLEY

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Tele-mental Health (TMH) Informed Consent

I, _____, hereby consent to engage in tele-mental health therapy with _____.
I understand that teletherapy includes the practice of health care including diagnosis, treatment, consultation, and education using HIPPA compliant interactive video.

I understand that I have the following rights with respect to tele-mental health:

1. I have the right to refuse TMH at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telehealth and the information disclosed by me in therapy is confidential with exception of the mandatory reporting laws that include but are not limited to: child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim, imminent risk of harm to myself, and if I make my mental or emotional state an issue in a legal proceeding. I understand my therapist might discuss my therapy with a consultant.

3. I understand that the dissemination of any personally identifiable images or information from our telehealth interaction shall not occur without my written consent.

4. I understand that TMH sessions are not being recorded, and that separate written approval and consent is needed in order to videotape a session.

5. I understand that there are risks from TMH that may include but are not limited to: the possibility, despite all reasonable efforts by my provider, that the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily.

6. I understand that while there is an empirical evidence base supporting the efficacy of TMH, it may not yield the same results as face-to-face services.

7. I will provide a phone number for follow-up contact should a technical failure occur.

8. I will provide the phone number for an emergency contact, and give consent for that person to be called if deemed necessary.

9. I understand that I have access to my medical information and copies of my medical records in accordance with MA laws.

10. I understand that I am responsible for: a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, b) ensuring security on my computer, and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

11. I understand that these services may not be covered by insurance and that I may be responsible for any fees incurred during psychotherapy incorporating TMH.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

Name_____ Date_____

Signature_____

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