Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Comprehensive Counseling Services (CCS) mental health professionals to connect with individuals using secure interactive video and audio communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

Your Rights, Benefits and Risks of Telehealth Services

I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and expressed threats of self-harm or suicide. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my mental health provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CCS utilizes secure, HIPAA compliant, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my mental health provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health provider associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to mental health treatment through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my provider, I may be directed to “face-to-face” psychotherapy.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the telehealth session at any time.
8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state of Wisconsin.
10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services
I understand that telehealth services are charged at the same rate as face-to-face services provided in the office as listed in the clinic's Financial Policy and Fee Schedule. I hereby authorize Comprehensive Counseling Services to bill my insurance company and release to my insurance company any information from my medical records that may be necessary to determine benefits payable under my policy for telehealth services. I understand that this information which may be transmitted electronically, may include the diagnosis and treatment of mental illness including alcohol and drug abuse, and developmental disabilities. I authorize payment directly to Comprehensive Counseling Services for the benefits otherwise payable to me for the amount that covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits. **I understand that I may be charged $75.00 for missed telehealth appointments as defined in the Financial Policy if not cancelled at least 24 hours prior to the appointment time.** I further understand that all co-payments are due at the time of service and that I am responsible for all balances to be paid within 90 days of the date of service regardless of the status of the insurance claims.

Patient Consent to the Use of Telehealth I have read and understand the information provided above regarding telehealth, have discussed it with my mental health provider, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

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Client Name

______________________________________ ____________________
Signature of Client Date

______________________________________ ____________________
Signature of Parent / Legal Guardian Date