Liberty House
375 Taylor Street NE
Salem, OR 97301

Telemental Health Informed Consent

Telemental health is the practice of providing behavioral health services via technology assisted media (e.g.; video sessions) or other electronic means when the therapist and client are in two different locations. While services at Liberty House Hope & Wellness will usually be in-person, there may be times when my provider offers the opportunity to engage in telemental health, such as during a public health emergency. By reviewing and completing the document below, I am offering consent for my minor child or self to receive telemental health services.

I understand the following about telemental health (please initial the lines as each item is read and complete form where appropriate):

Technology:

_____ Any and all technologies used will include software security protocols to safeguard the confidentiality of my protected health information. These protocols include measures to protect against intentional or unintentional breaches.

_____ There are benefits and risks associated with telemental health, including but not limited to: disruption of transmission due to technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

_____ I will need a tablet, laptop or smart phone in order to participate in the service provided

_____ There will be no recording of any online sessions by myself or my provider.

If service is disrupted, end and restart the session. If unable to connect within 10 minutes, I ask that my provider call me at: _____ to discuss whether to continue via phone or reschedule.

Exchange of Information/Privacy:

_____ Any exchange of written information will not be direct during the use of telemental health and will likely be provided through electronic means or postal service.

_____ During telehealth sessions, personal health information will be discussed through the use of interactive video, audio or other telecommunications technology.

_____ It is my responsibility to maintain privacy on my (the client) end of communication. I understand it is strongly advised to select a location during my session that will limit exposure of my personal information to others in the home (with the exception of family sessions).

_____ For parents/guardians of children 18 and under: I understand that my child needs to be provided with a space that is safe and private for their telemental health session. I will allow my child to engage in the session alone unless otherwise requested by the therapist.

_____ All information disclosed during sessions and written records pertaining to those sessions are confidential and may not be shared with anyone without written authorization, except where the disclosure is permitted or required by law.

_____ Insurance companies, those authorized by myself (or guardian if under 14), and those permitted by law such as mandatory reporting may have access to records or communications.

I will take the following precautions to protect my personal health information during telemental health sessions (consider location, who is present, etc):

1. _____
2. _____
3. _____

Telemental health Process:

_____ Telemental health sessions will differ from in-person sessions, including but not limited to emotional reactions that may arise from the technology.

_____ Some information my therapist would usually get in face to face sessions may not be available or obvious in telemental health (e.g., body posturing, facial cues, tone of voice). I understand that such missing information could, in some situations, make it more difficult for my therapist to understand my problems and help me grow.

_____ I acknowledge that if I choose to withhold information it may impact diagnosis as well as treatment direction and progress.

Emergency/Crisis:

_____ I understand that if I (or my minor child) am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

_____ My therapist will be unable to render in-person assistance if I experience an emergency.

In case of emergency or mental health crisis, this is the address where I will be during my telemental health sessions:

_____

I agree to inform my counselor if I am at a different location at the start of the session.

These are the names and telephone numbers of my local emergency contacts (these persons will only be contacted to go to your location or take you to the hospital in the event of an emergency or mental health crisis, starting with the first person on the list):

1. _____
2. _____
3. _____

Discontinuation of Telemental Health Services:

_____ I have the right to withdraw consent at any time without affecting my right (or that of my minor child) to future care, services, or program benefits to which I would otherwise be entitled.

_____ I understand that at any time, telemental health services may be discontinued by either me, my guardian, or my therapist.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of telemental health between my therapist and me (and/or my minor child), and consent to the conditions outlined above.

Client: _____ Date: _____
Signature (if 14 or older)

Client: _____ DOB: _____
Printed Name

For clients under 14:

Parent/Guardian: _____ Date: _____
Signature

Parent/Guardian: _____ Date: _____
Printed Name

Provider: _____ Date: _____
Signature

Provider: _____ Date: _____
Printed Name