Prairie Psychotherapy Services
335 N River St #210
Batavia, IL 60510

CONSENT TO TELEHEALTH

I, _____, am seeking telehealth services and hereby consent to participate in telehealth. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a patient who are located in two different locations.

I understand the following with respect to telehealth:

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

2) I understand that there are risks and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that telehealth is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service that should be discussed with my clinician.

4) I understand and agree that there will be no recording of any of the telehealth sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

5) I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse or neglect; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

6) I understand that the tele-conferencing platform selected for our virtual sessions will have appropriate technical safeguards. I know it is important that I use a secure internet connection rather than public/free Wi-Fi. It is also important to be in a quiet, private space where I can speak freely without fear of being overheard. I understand that my clinician cannot guarantee I will not be overheard in my location, and I need to ensure privacy in my location.

7) I understand that if I 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 telehealth services are not appropriate and a higher level of care is required.

8) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs and we are not able to reconnect within ten minutes, we may have to re-schedule.

9) I understand that my therapist needs to know my location when my session begins and may need to contact my emergency contact and/or appropriate authorities in case of an emergency. Emergency Protocols.

10) I understand that all of Prairie Psychotherapy Services normal administrative policies concerning scheduling and billing will apply. See prairiepsychotherapyservices.com "Psychotherapist-Patient Services Agreement" for more information.

11) I understand I should confirm with my insurance company that the teletherapy sessions will be reimbursed; if they are not reimbursed, I know I am responsible for full payment.

12) I understand that my clinician may determine that due to certain circumstances, teletherapy is no longer in my best interest. Should this occur, my therapist will discuss it with me. It will often be best to resume in-person sessions.

In addition to the above understandings, I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone is: _____

I have read the information provided above and discussed it with my psychotherapist. I understand the information contained in Prairie Psychotherapy Services CONSENT FOR TELETHERAPEUTIC SERVICES.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

Name_____
Signature_____ Date_____

Therapist Name_____
Signature_____ Date_____