Touma & Associates

Telehealth Treatment Consent

Information and Informed Consent for Tele-mental Health Treatment

Tele-mental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding:

I understand that tele-mental health services are completely voluntary and that I can withdraw this consent at any time.
I understand that none of the tele-mental health sessions will be recorded or photographed.
I agree not to make or allow audio or video recordings of any portion of the sessions.
I understand that the laws that protect privacy and the confidentiality of client information also apply to tele-mental health, and that no information obtained in the use of tele-mental health that identifies me will be disclosed to other entities without my consent.
I understand that tele-mental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.
I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
I understand that I or my therapist may discontinue the tele-mental sessions at any time if it is felt that the video technology is not adequate for the situation.
I understand that if there is an emergency during a tele-mental health session, then my therapist may call emergency services and/ or my emergency contact.
I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to tele-mental health services.
I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.
I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.
I understand my therapist will advise me about what tele-mental health platform to use and she will establish a video conference session.

Client Consent

I hereby give my informed consent to ABH for the use of tele-mental health in my care.

Client Name: _____ Date of Birth: _____

Email: _____

Phone Number: _____

Client Signature: _____ Date: _____