ELMERGREEN ASSOCIATES

Tele-behavioral Health Informed Consent

Due to the COVID-19 outbreak, Elmergreen Associates is offering telehealth psychotherapy sessions for the purpose of protecting the physical health of clients and staff members of Elmergreen Associates. Your therapist will either be providing telehealth in their office at Elmergreen Associates or at their home in a secure room if the therapist is deemed to be high risk for respiratory issues or is being quarantined.

I understand and agree to receive telehealth psychotherapy services from my therapist. This mean that my therapist and I will, though a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telehealth psychotherapy, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telehealth psychotherapy is not an appropriate method of treatment for me.

I recognize the benefits of telehealth psychotherapy, which may include the following: 1) allowing me to practice safety precautions regarding the COVID-19 outbreak 2) reduced cost, time and commitment for treatment due to the elimination of travel; 3) ability to receive services near my home or from my home; and 4) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio, and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recoding my session is prohibited.

I agree to take full responsibility for the security of any communication or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to assess the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral if travel to the therapist's office is more feasible for me.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participation in telehealth psychotherapy under the conditions described in this document.

Client Name (please print): _____ **Date:** _____

Legal Guardian (if applicable): _____

Relationship to client: _____

Client/Guardian Signature: _____ **Date:** _____