



Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to allow Transformations of Statesboro counselors to connect with individuals and families using interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, and referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth, for myself and/or my minor child:

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 where I make my mental or emotional state an issue in a legal proceeding. 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 the counselor, 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. Transformations of Statesboro utilizes secure, encrypted audio/video transmission software to deliver telehealth.
4. I understand that if my 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 professional associated with any form of mental health services, 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 services 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” mental health services.
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 at the onset of the session, 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 consultation 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 in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based mental health 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.

11. I understand that different states have their own regulations for the use of telehealth. Transformations of Statesboro and their Providers will follow all guidelines for Georgia and their respective licensing boards.

Payment for Telehealth Services:

Transformations of Statesboro will require clients to complete a Credit Card on File Form or accept payment the time of scheduling. We will provide you with a receipt.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my 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. 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.

Patient Name

Parent/Guardian Name

Patient or Parent/Guardian Signature

Date