GROSSMAN & GROSSMAN LTD

Telehealth Client Consent Form

Client Name:_____Date of Birth:_____

1. PURPOSE: the purpose of this form is to obtain your consent to participate in telehealth for the purposes of behavioral health counseling and related case management. The use of telehealth includes the importance of informed consent, the limits of confidentiality, and the best uses of technology.
2. NATURE OF TELEHEALTH SESSION: the telehealth session is the provision of interactive counseling services by a therapist to improve access to care and address behavioral health concerns. An intake session will allow for a thorough assessment, history taking, and the identification of referring concerns to be addressed in the counseling. The counseling sessions will be provided via secure phone or video using your computer or smartphone. The provision of telehealth counseling may also include the scheduling of face-to-face sessions between the therapist and client.
3. RECORDS: All existing laws regarding your access to behavioral health information and copies of your treatment records apply to telehealth counseling. Dissemination of any information related to your counseling will not be made without your specific written consent.
4. CONFIDENTIALITY: It is important that the therapist and the client both are in confidential settings when the telehealth counseling occurs and are not in a setting where disclosed information could be overheard or witnessed by non-authorized individuals. All existing laws regarding confidentiality apply to telehealth counseling. All individuals present will identify themselves at the start of the session.
5. RIGHTS: You may withhold or withdraw consent to telehealth counseling at any time without affecting your right to future treatment with this agency.
6. TECHNOLOGY: All sessions will be conducted via encrypted video-communication originating from our EMR platform or ZOOM. Clients will be provided with a secure link to click on to start a single session and will need to have an established secure environment for the counseling. Recording of services is not allowed.
7. CRISIS: At the start of each session, your therapist will ask you the following information to ensure that if there is an emergency or a break in contact during the session, the therapist has the necessary information to make contact with the client/family (Name, Location, Phone Number, Emergency Contact). If a client/family requires immediate assistance, local crisis services and/or hotline will be provided along with the therapist's direct cell phone number.
8. ACKNOWLEDGEMENT: I acknowledge that if I am facing, or think I may be facing, an emergency that could result in harm to me or to another person, I am not to seek telehealth counseling. Instead I agree to seek care immediately through local crisis resources or at the nearest hospital emergency department or by calling 911.

I agree to participate in telehealth counseling:

Print Name:_____Signature:_____

Relationship to Client:_____ Date:_____

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