Client Name:_____

I, _____, agree to participate in teletherapy with a mental health provider at Renew Wellness (Russell Medical).

This means that:

- *I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between Renew Wellness (Health Fusion, Doxy.me, Zoom, Simple Practice, Theranest or Face Time) I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.*
- *My therapist/psychiatrist has explained how the teletherapy system works and how it will be used for my treatment.*
- *My therapist/psychiatrist has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.*
- *I understand that my therapist will not be physically present during my teletherapy session. Instead, we will see each other electronically.*
- *I understand that teletherapy is a new form of treatment that is not yet validated by research. As such, there may be potential risks that may not yet be recognized.*
- *Potential risks include the following: (a) at times the video image may be unclear or inadequate; (b) a disruption in the connection may occur; and (c) in rare circumstances, the information may be intercepted by unauthorized persons.*
- *I authorize the release of information pertaining to me determined by my mental healthcare providers or by my insurance company for the purpose of processing insurance claims.*
- *I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My therapist will refer me to a local mental health provider who can provide face-to-face services if available.*
- *I understand that, under the law, my mental health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.*
- *My therapist/psychiatrist have explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in person.*
- *I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.*

- *I understand that as part of receiving teletherapy, some information will be used for research purposes. No identifying information will be revealed to anyone other than those involved in my treatment at Renew Wellness. I have received a list of emergency contacts by my therapist.*

I voluntarily consent to participate in telemental health services using videoconferencing equipment for the care, treatment, and services deemed necessary and advisable under the terms set forth herein.

Signatures

Name: _____ *Date:* _____

Witness (therapist can sign): _____ *Date:* _____

Parent or Legal Guardian: _____ *Date:* _____