THE INSTITUTE FOR CHANGE
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Suite 211
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Teletherapy Informed Consent

I, ______________________________ (name of client) hereby consent to participate in Teletherapy, and/or authorize my child, _____________ to participate in Teletherapy with_________________________, (name of provider) as part of my/their psychotherapy. I understand that Teletherapy is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Teletherapy:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with Teletherapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not he disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Teletherapy is not appropriate and a higher level of care is required.

6) I understand that during a Teletherapy session, we could encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, the phone number I enter below can be called to discuss other options or times to speak.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Additional Considerations:

Please make sure in advance that your device has an adequately charged battery. You may want to use Wi-Fi or an Ethernet cable connection to prevent data charges.

You should be in a private, not public place (like a coffee shop). For your privacy, others should not be in the room with you. Your therapist will be in a private location. You may wish to use headphones or an attached speaker depending on your privacy and hearing needs.

Emergency Protocols:

Your therapist needs to know your location in case of an emergency. Please supply your address at the beginning of each session and a phone number where you can be reached. Please also supply below a contact person who may be contacted on your behalf in a life-threatening emergency ONLY. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my usual location will be: ____

And my phone number in case we need to speak directly is_____________________________________

And my emergency contact person's name, address and phone is:

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I have read the information provided above and discussed it as needed with my therapist. I understand the information contained in this form, and all of my questions have been answered to my satisfaction.

____

Signature of Client/Parent/Legal Guardian Date

Please return this form to IFC via USPS: IFC, PO Box 289, Caldwell, NJ 07006

Or fax: 973-403-2927