**Telemental Health Informed Consent**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been offered behavioral health services by City of Tempe Counseling Services staff via telemedicine. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time City of Tempe Counseling Services staff will ensure that the standard of care delivered via telemental health is equivalent to any other type of care that can be delivered to the client, considering the specific context, location and timing, and relative availability of in-person care.

I understand that there is a possibility of technology failure on the part of myself or my counselor and arrangements will be made to reschedule my appointment or find alternative mediums of service as necessary. Industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption.

There are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider.

I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area.

To maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment.

The communication is privileged and confidential and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time. If at any time, counseling services are deemed ineffective by my counselor or myself, my counselor will assist me in identifying appropriate services.

*Appropriateness of Telemental health services*

There are specific considerations when a client is considering utilizing Telemental health services such as their treatment goal, type of the service delivery (phone, video), associated needs to receive services (computer with specific capabilities), limitations to confidentiality, privacy concerns, possibility of technology failure, anticipated response time to electronic communication, and any additional considerations. If Telemental health services are not appropriate for the client, appropriate alternate referrals will be provided. I understand the factors at play in determining if Telemental health services is appropriate for my counseling needs.

*Limitations to confidentiality, security,*

I understand that my privacy and confidentiality will be protected by City of Tempe Counseling Services. I understand that my clinical documents will be viewed by the counselor’s supervisor and colleagues to ensure an appropriate level of care is being provided. City of Tempe Counseling Services utilizes secure, encrypted networks for the storage of documents and client records. There is also a risk if the client’s computer is using a public network to or is on a shared computer. We would recommend that the client does not utilize “auto remember” services if receiving counseling services on a public computer or a computer using a shared network. City of Tempe Counseling Services will take additional steps to minimize the risk of the counselor inadvertently sending confidential information to unauthorized individuals. I understand the inherent limitations to confidentiality when using telemedicine even while using secure, encrypted networks and that there may be authorized or unauthorized access to the information disclosed. When I am receiving services via telemedicine, I will be notified as to who is in the room at the location of my counselor. I understand that I am responsible for the access permitted to my confidential information via my location.

In order to ensure the privacy and confidentiality of the client, we will verify by site or photo ID that the client is the identified client for each and every session.

*Telemental health counseling for minors*

I understand that if I am under 18 years of age I will be required to gain my parents/caregivers’ permission before I would be able to receive Telemental health services. My caregiver/parents and I understand that a legal guardian/parent must be home when I have my counseling session via telemental health.

Records

I understand that my record will be maintained in a physical and digital format according ARS 12-2297 Retention of records statute, which is 6 years for an adult and for minors at least 3 years after the 18th birthday or at least 6 years after the last date of service, whichever is later.

I understand that the counselor will keep copies of all written communications with telemental health with clients and they will be subject to the same retention of records statutes listed in ARS 12-2297.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record. Please check and initial the appropriate box below.

I do hereby agree to participate in telemental health counseling until my date of termination from counseling services or the specified date\_\_\_\_\_\_\_\_\_\_\_\_.

 □ I agree to participate in and receive behavioral health services via telemedicine

 □ I have chosen not to participate in telemedicine sessions.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Partner, Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_