Blue Ridge Psychological Center

TELEHEALTH / TELETHERAPY CONSENT FORM

(REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

Definition of Services:

By signing this form I am consenting to engage in teletherapy with my provider at Blue Ridge Psychological Center (BRPC). Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/ mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I understand that I have the following rights with respect to teletherapy:

1. I, the client, need to be a resident of Virginia and be located in Virginia at the time of the teletherapy service.

2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy follows the same guidelines that I have previously agreed to when signing the general informed consent paperwork at BRPC.

4. I understand that there are risks and consequences when participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be

interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

6. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

7. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area.

8. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.

9. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency department for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my provider will recommend more appropriate services.

10. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

I have read, understand and agree to the information provided above regarding telehealth,

_____
Printed Name of Patient/Parent/Legal Guardian

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Signature of Patient/Parent/Legal Guardian

Date_____