The Center for Human Development is offering telehealth psychotherapy sessions. Be assured that your therapist will be providing services from a HIPAA compliant and secured location.

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telemental health, which may include the following: 1) the video connection may not work, or it may stop working during a session; 2) the video or audio transmission may not be clear; and 3) I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following: 1) allowing me to practice safety precautions regarding potential illness; 2) reduced cost and time and commitment for treatment due to the elimination of travel; 3) ability to receive services near my home or from my home; and 4) access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via videoconferencing. I understand that my therapist uses HIPAA-compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my session is prohibited.

I agree to take full responsibility for the security of any communication or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to assess the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that I have the option to request in-person treatment at any time, and my therapist will assist in scheduling this or make a referral to another counselor, if for any reason face to face services are not a viable option either for the therapist or the client.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participation in telemental health under the conditions described in this document.

Client Name (please print): _____ **Date:** _____

Legal Guardian (if applicable): _____

Relationship to client: _____

Client/Guardian Signature: _____ **Date:** _____

Document last edited 3/23/20