Telemental Health Informed Consent

Child/Youth Name:

Date of Birth:

Definition of Telehealth

Telehealth involves the use of electronic communications to enable Old Mill Center mental health professionals to connect with individuals using interactive video and/or audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. This form grants permission for Old Mill Center for Children and Families (OMCCF) counseling staff to provide assessment and mental health services utilizing telemental health mediums.

Risks and Benefits

I understand that I have the following rights with respect to telemedicine for my child:

1. _____ I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment for my child nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

2. _____ The laws that protect the confidentiality of medical information also apply to telemedicine. As such, I understand that the information disclosed by my child during the course of their therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)
   I also understand that the dissemination of any personally identifiable images or information from the teleedicine interaction to researchers or other entities shall not occur without my written consent.

3. _____ I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my child's psychotherapist, that: the transmission medical information could be disrupted or distorted by technical failures; the transmission of medical information could be interrupted by unauthorized persons; the electronic storage of medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my child's psychotherapist believes we would be better served by another form of psychotherapeutic service (e.g. face-to-face service), we will be referred to a psychotherapist in my area who can provide such service. Finally, 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 psychotherapist, my child's condition may not improve and in some cases may even get worse.

4. _____ I understand that my child may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

5. _____ I understand that I have the right to access my child's medical information and copies of medical records in accordance with Oregon law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

6. _____ By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If my child is in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it OMCCF staff, and all my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services with my child for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____	_____	_____
Signature of Responsible Party	**Relationship to Client**	**Date**
_____	_____	_____
Signature of Responsible Party	**Relationship to Client**	**Date**

_____

Print Name of Client

Fee arrangements may be reviewed with your provider at any time. For information regarding your bill, please contact our Billing Office.