Old Mill Center for Children and Families
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Telemental Health Informed Consent

Client Name: _____

Date of Birth: _____

Definition of Telemental Health

Telemental health 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. Telemental health 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

Please review and initial spaces below. I understand that I have the following rights with respect to telemental health services:

1. _____ I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment 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 telemental health. As such, I understand that the information disclosed by during the course of their treatment 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.)

3. _____ I understand that I have the right to a confidential space for telemental health appointments. This includes but is not limited to the environment in which the telemental health session is taking place and those around me. It is my responsibility to assist in developing a space for the telemental health appointments to occur that meets the confidentiality expectations as agreed upon by myself and the providers involved through the telehealth appointments upon the start of services.

4. _____ I understand that there are additional risks and consequences from telemental health. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my 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.

5. _____ I understand that telemental health-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 psychotherapist believes I 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 if they are unable to provide directly. 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 condition may not improve and in some cases may even get worse.

6. _____ I understand that I may benefit from telemental health, but results cannot be guaranteed or assured. The benefits of telemental health 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.

7. _____ I understand that I have the right to access my 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.

8. _____ I agree to create and maintain a safety plan if needed in collaboration with my provider in the event there are concerns or risks identified. I will also provide the contact information or alternative means to reach another adult if I am unavailable that can intervene since the providers may be remote at the time of crisis and need an in-person intervention. I also understand that If I am 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.

Client Consent to the Use of Telehealth

I have read and understand the information provided above regarding telemental health, 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 telemental health services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telemental health services 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.

_____	_____	_____
Name of Individual Served	**Signature of Individual Served** (if 14 or older)	**Date**

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

(Required if the individual served is a minor or an adult who is unable to sign this form)

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

(Required if the individual served is a minor or an adult who is unable to sign this form)