***Julie Johnson MA LCPC***

***2656 W. Montrose Ave***

***Chicago, IL 60618***

**INFORMED CONSENT FOR TELEHEALTH SERVICES**

*Due to the current COVID-19 pandemic, our sessions will take place by video/telehealth or telephone. We both understand this is temporary and that our in person/face to face sessions will resume once the pandemic is over. I, the recipient, of services agree to the following:*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to participate in telemental health as part of my services. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between the therapist and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (“PHI”) also apply to telemental health unless an exception to confidentiality applies. I understand that my therapist is conducting telemental health services on a secure, HIPAA compliant platform, Doxy.me.

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at **773-383-7033** to discuss since we may have to re-schedule.

EMERGENCY PROTOCOLS: You agree to provide your location in case of an emergency to your therapist. You agree to inform your therapist of the address where you are at the beginning of each session. Your therapist will require that an emergency contact person may be contacted in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Signature of Patient/Patient’s Legal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_