

**Partners for Healing and Changework
520 Stokes Rd. C-4
Medford, NJ 08055
609-714-0222**

Telemental Health Informed Consent

This Informed Consent form is intended to inform you about our policies and procedures regarding Telemental Health Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, have acknowledged that you understand and agree that your therapist with Garden State Behaviora Health Services will provide therapy to you according to this Telemental Health Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telemental health services, and agreed upon before any Telemental health services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telemental health services.

I understand that Telemental health services (also referred to as e-therapy, teletherapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemental health services. My rights to confidentiality with Telemental health services are exactly the same as my rights for in-person therapy services. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

Therapeutic treatment for mental health, both in person and through Telemental health services, has been found to be effective in treating a wide range of clients, though individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Telemental health services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemental health services, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, my therapist can be contacted at _____. ***By signing this consent form, I am acknowledging that I know how to contact my provider in case of a disruption or emergency.***

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information

from the Telemental health services interaction to any other entities shall not occur without my explicit written consent. Your therapist and Partners for Healing and Changework also agree to under no circumstances take any personally identifiable images from the session or store any of these images on personal or business devices from Telemental health services.

I also understand that my Telemental health services appointment time is reserved exclusively for me. If I cannot attend my scheduled appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. If I do not provide 24 hour notice for non-emergency reasons a late cancellation fee will apply.

In accordance with our Consent for Treatment If you are unable to attend a scheduled appointment, you will be expected to pay a late cancellation fee unless you provide a 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Similarly, if I am late to my scheduled session, I will receive my service for the remainder of my scheduled session time slot without refund.

Also, due to licensing requirements I agree to be physically in New Jersey each session and to give my current physical address accurately at the beginning of each session. I agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.

In accordance with the American Telemedicine Association (ATA) I agree to have Telemental health services sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed using the google speed test. Google 'speed test' and use the google version. These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.

I understand that Telemental health services appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one present in the room.

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telemental health services in the course of my care at any time, without affecting my

right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting PHC at 609-714-0222

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Telemental health services Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemental health services via an online HIPAA compliant telemedicine platform with the clinician listed below:

Client Name (printed): _____

(or parent or legal guardian)

Client signature: _____

(or parent or legal guardian)

Clinician: _____

Date (mm/dd/yy): _____