CALM & SENSE THERAPY

Telehealth Informed Consent

Telehealth is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations. Calm and Sense Therapy uses the Zoom platform to conduct Telehealth sessions; it offers secure, encrypted audio/video transmission software. To participate in Zoom sessions, the client and clinician will need to utilize the device of their choosing with video and audio capabilities. Audio-only (phone) sessions will be conducted only in the event that the staff member and/or client does not have access to the necessary equipment and/or software or for other discussed reasons out of their control.

I understand the following with respect to telehealth:

MY RIGHTS AS A TELEHEALTH CLIENT

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

2) I understand that there will be **no recording** of any 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 my written authorization, except where the disclosure is permitted and/or required by law.

3) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth **unless an exception to confidentiality applies** (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

4) I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

MY RESPONSIBILITIES AS A TELEHEALTH CLIENT

5) I understand that I must provide my clinician with the **address of my physical location at the outset of the session** in the event of an emergency that requires the dispatch of support.

6) It is my responsibility to ensure that the session is taking place within the state of my clinician's licensure (NJ) and only in a safe, sufficiently private and therapeutically conducive space. In addition, it is my responsibility to alert my clinician if privacy has been disrupted in any way during the session (ie. family member has suddenly entered the room) as to pause the conversation until privacy is restored.

7) I understand that I will need to ensure that I am prepared to start my scheduled telehealth session on time and if I will be late, I need to alert my therapist via call or email. If I need to ultimately cancel or reschedule, I must provide my clinician with **at least 24-hours notice** or I will incur a **"late cancellation fee" of $75** which will be charged to the card on file. Communicated **emergency exceptions** will be honored and not incur a charge.

8) I understand that there are risks and consequences associated with telehealth, 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.

9) I understand that during a telehealth video session, we could encounter technical difficulties resulting in service interruptions. If this occurs, my therapist will encourage me to end and restart the session. **If we are unable to reconnect within 5 minutes, my therapist may call me at (please provide preferred contact number) _____ to resume via phone call**. If for whatever reason the connection cannot be restored promptly, the session will be billed for the time completed and my clinician will contact me with the next available appointment.

TELEHEALTH EMERGENCY PROTOCOLS:

10) I understand that as much as my assigned clinician will be a trained professional equipped to support me with my presenting concerns, there are certain situations, including emergencies and crises, which are inappropriate for audio-/video-/computer-based psychotherapy services. **If I am in crisis or in an emergency, I understand that I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. After this point, I can then inform my clinician of the events and seek additional support.**

11) I understand that if at any point during my services my clinician believes that I would be better served by another form of intervention (e.g., face-to-face services), they will outline a plan for me which may entail office visits or a referral to another mental health professional. **Such circumstances include but are not limited to:** If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely.

12) I understand that I must provide the name and contact information of the emergency contact my therapist will reach out to on my behalf in a life-threatening emergency only. **This person must live with me or within 30 minutes of my location.** I understand that this person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

My emergency contact is (Name): _____
Address: _____
Phone: _____

SIGNATURES

I have read the information provided above and discussed it with my therapist to ensure my full understanding. All of my questions have been answered and I am ready to proceed with telehealth.

Signature of client/parent/legal guardian: _____ Date: _____

Signature of Therapist: _____ Date: _____