THE COMMUNITY COUNSELING CENTER OF MOORESTOWN VNA

Telehealth Consent

Date **Client/Guardian**

1. I understand that my Therapist recommends engaging in telehealth services with me to provide treatment.
2. I understand this is out of necessity and an abundance of caution and has originated due to the Coronavirus (Covid-19) pandemic. This will continue until such time that we are able to meet in person, or could continue, depending on the particular circumstance.
3. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to services. I understand; however, there is no guarantee that all treatment of all clients will be effective.
4. I understand that it is my obligation to notify my Therapist/CCC of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my Therapist/CCC of the change in location.
5. I understand that it is my obligation to notify my Therapist/CCC of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my Therapist at the outset of each session and am aware that confidential information may be discussed.
6. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.
7. I agree that I will not record either through audio or video any of the session, unless I notify my Therapist/CCC and this is agreed upon.
8. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.
9. I understand that my Therapist/CCC is not responsible for any technological problems of which my Therapist/CCC has no control over. I further understand that my Therapist/CCC does not guarantee that technology will be available or work as expected.
10. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.
11. I understand that my Therapist/CCC or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/session if it is determined by either me or my Therapist/CCC that the videoconferencing connections or protections are not adequate for the situation.

12. I have had a conversation with my Therapist/CCC, during which time I have had the opportunity to ask questions concerning services via telehealth. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me.
13. Zoom [Name of the Telehealth Service to be used] is the technology service we will use to conduct telehealth videoconferencing sessions. My Therapist/CCC has discussed the use of this platform. Prior to my first session, if applicable, I will receive a Zoom ID to enter the "virtual waiting room" until the session begins. There are no passwords or log in required.

By signing this document, I acknowledge:

1. Zoom [Name of the Telehealth Service to be used] is NOT an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.
2. I recognize my Therapist/CCC may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my Therapist/CCC is concerned that immediate medical/psychiatric attention is needed.
3. Though my Therapist/CCC and I may be in virtual contact through telehealth services, neither Zoom [Name of the Telehealth Service to be used] or my Therapist/CCC provides any medical/ psychiatric or emergency or urgent healthcare services or advice. I understand should medical/psychiatric services be required, I will contact my physician. If emergency services are needed, I understand I should call 9-1-1.
4. Zoom [Name of the Telehealth Service to be used] facilitates videoconferencing and this technology platform is not, itself, a source of healthcare, medical or psychiatric advice, or care.
5. During these times of the impact of Coronavirus (Covid-19) my therapist may not have access to all of my psychiatric/treatment records. My Therapist/CCC has made reasonable efforts to obtain records, but I understand and agree this may not be reasonably possible.
6. To maintain confidentiality, I will not share my telehealth meeting ID Number or information with anyone not authorized to attend the session.
7. I understand that either I or my Therapist/CCC can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

I have read and understand the information provided above regarding telehealth, have discussed it with my Therapist/CCC, and I hereby give informed consent to the use of telehealth.

_____	_____
Signature of client (or guardian/conservator)	Signature of Therapist
_____	_____
Printed name	Printed name
_____	_____
Date	Date