



## Informed Consent for Teletherapy

CLIENT NAME:

DOB:

RECORD#:

LOCATION OF CLIENT:

TREATING THERAPIST:

DATE OF CONSENT:

LOCATION OF TREATING THERAPIST:

For clarifying purposes, the terms “**PCS**”, “**we**”, “**us**”, or “**our**” refer to PCS, Inc. and the terms “you” and “yours” refer to the client identified above. “Provider”, “therapist”, and “clinician” refer to the psychotherapist providing services to the client above.

“**Teletherapy Services**” involves the delivery of health care services using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with the agency (“**PCS, Inc.**”) and a client who are not in the same physical location. Teletherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a client and a provider;
- Interactions between a client and provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of Teletherapy Services has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information. PCS uses a HIPAA-compliant platform for all telehealth services.

### **Possible Benefits of Teletherapy**

- Easier access and efficiency in attaining clinical care and treatment from a provider
- Ability to better obtain services from a provider; more flexible scheduling during times of geographical, governmental, weather-related, or transportation limitations
- Ability to interact with a provider without the necessity of an in-office appointment

### **Possible Risks of Teletherapy**

- Information transmitted to your provider may not be sufficient to allow for appropriate clinical decision making by the provider in some situations.
- Your provider may not be able to provide clinical treatment for your particular condition via teletherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your provider’s treatment options may be limited.



## Informed Consent for Teletherapy

By accepting this Consent for Teletherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via teletherapy is an evolving field and that the use of teletherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of teletherapy may provide potential benefits to me, as with any clinical care service, no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my provider may determine in his or her sole discretion that my condition is not suitable for treatment using teletherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of healthcare may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these teletherapy services.
7. I agree and authorize my provider and agency to share information regarding the teletherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new teletherapy consultation with my provider.

### **Client Consent to the Use of Teletherapy**

I have read this Informed Consent for Teletherapy carefully, and understand the risks and benefits of the use of teletherapy in the course of my treatment. I have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my mental health care at PCS.

**I, \_\_\_\_\_ hereby authorize my provider,  
to use teletherapy in the course of my diagnosis and treatment.**

**Signature of Client (or authorized signer for client):**

**Date:**

**If authorized signer, relationship to client:**

**Signature of Treating Provider:**

**Date:**

**I agree that I have been offered a copy of this consent form.**