

Telehealth Informed Consent Form

I, _____, consent to engaging in telehealth with NeuroPsych Center of Greater Cincinnati as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, medication management and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,
3. I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of NeuroPsych Center of Greater Cincinnati that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my provider believes I would be better served by other interventions I will be referred to other mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my provider, my condition may not improve, or may have the potential to get worse.

4. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, Zoom, and Google audio/video systems are not 100% secure and may have issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold NeuroPsych Center of Greater Cincinnati or its staff liable for gathering or use of client information by these service providers.
5. I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my provider, and all of my questions regarding the above matters have been answered to my approval.



- 6. By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychiatry/psychological services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

Patient Consent to the use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize NeuroPsych Center of Greater Cincinnati to use telemedicine in the course of my diagnosis and treatment.

_____	_____	_____
Patient Signature (or Authorized Signer)	Date	Relationship to patient if authorized signer
_____	_____	
Witness Signature	Date	

I have been offered a copy of this consent form (patient's initials) _____