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35037 Royal Place \* Soldotna, AK 99669 \* (907) 260-7423

## Informed Consent for Tele-behavioral Health Services

Date: \_\_\_\_\_ Name of Person completing form: \_\_\_\_\_

Client name: \_\_\_\_\_

Location of Client: \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Phone number: \_\_\_\_\_ Alternative number: \_\_\_\_\_

Emergency contact (1) \_\_\_\_\_ phone number: (1) \_\_\_\_\_

Emergency contact (2) \_\_\_\_\_ phone number: (2) \_\_\_\_\_

Local Hospital: \_\_\_\_\_ phone number: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Physical address:

City, State, Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

***New Hope Counseling Center uses VSee, a secure video conferencing site. This works similarly to Skype, but is HIPAA compliant. Please download the program or app to the device you will be using for sessions.***

*"Find rest, O my soul, in God alone; My hope comes from him." Psalm 62:5*

## **Introduction**

Tele-behavioral Health involves the use of electronic communications to enable therapists to provide services to individuals who would otherwise not have adequate access to care. Tele-behavioral Health may be used for services such as individuals, couples, or family therapy, follow ups, and training/education in a group setting. Tele-behavioral Health is a fairly recent way of delivering care and there are some limitations compared with seeing a therapist in person. Limitations include not having the person-to-person contact and not being an adequate fit for all populations. The limitations can be addressed and are fairly minor depending on how well the sound and video are working during the Tele-behavioral Health session.

## **Expected Benefits:**

Improved access to care by enabling individuals to remain in their community

Access to the expertise of a specific specialist

## **Possible Risks:**

There are potential risks associated with the use of Tele-behavioral Health. These risks include, but may not be limited to:

Information transmitted may not be sufficient (e.g. Poor resolution of images) to allow for appropriate treatment such as play therapy

Delays in treatment could occur due to the deficiencies or failures of equipment

In very rare instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a breach of privacy.

## **Additional Points for Client Understanding:**

1. I understand that Tele-behavioral Health services are completely voluntary and that I can choose not to do or not to answer questions at any time.
2. I understand that none of the Tele-behavioral health sessions will be recorded or photographed.
3. I understand that the laws that protect privacy and confidentiality of client information also apply to Tele-behavioral health, and that no information obtained in the use of Tele-behavioral health which identifies me will be disclosed to other entities without my consent.
4. I understand that because this is a technologically-based method, sometimes it may be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
5. I understand the Tele-behavioral health is done over secure communication system that is almost impossible for anyone else to access, but that since it is still a possibility, I accept the very rare risk that this could affect confidentiality.
6. My therapist explained to me how the videoconferencing technology will be used. I understand the Tele behavioral health sessions will not be exactly the same as in person session due to the fact that I will not be in the same room as my therapist.



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- 7. I understand there are potential risks of technology, including interruptions, unauthorized access, and technical difficulties. I understand my therapist or myself can discontinue the Tele-behavioral Health sessions if it is felt that the videoconferencing connections are not adequate for the situation.
- 8. I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.
- 9. I understand that I may experience benefits from the use of Tele-behavioral health in my care, but that no results can be guaranteed or assured.
- 10. I understand that if there's an emergency during a Tele-behavioral health session, my therapist will call emergency services and my emergency contacts.
- 11. I understand that if the video conferencing connection drops while I am in a session, that I will have a phone line available and to contact my therapist.
- 12. I understand that I will be asked to create a safety plan with my therapist in case of an emergency.

*I understand the information provided above regarding Tele-behavioral health. I have discussed the consent with my therapist or assistant as maybe designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Tele-behavioral health in my care.*

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(or person authorized to sign for patient)

**If authorized signer, relationship to patient:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I have been offered a copy of the consent form (client's initials):** \_\_\_\_\_



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## Tele-behavioral Health Safety Plan

I have provided New Hope Counseling Center with two emergency contact numbers and the number to the local hospital.

If there's an emergency during the session, my therapist has permission to contact my emergency contacts and the local hospital.

I have provided new hope counseling center with a working telephone number to reach me if the video conferencing connection fails during the session.

New Hope Counseling Center has provided me with a contact number. If connection fails and New Hope Counseling Center does not call me back within five minutes, then I will call the counseling center.

Additional items (if needed): -

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Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_  
(or person authorized to sign for client)

Authorized signer, relationship to client: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_