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**Telehealth Informed Consent**

I \_\_\_\_\_ [client] hereby consent to engaging in telehealth with Cornerstone Counseling as part of my mental health therapy. I understand that “telehealth” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Ohio.

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

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or 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 my mental health therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the

transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of mental health therapeutic services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my mental health therapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law.

(6) I agree to keep a credit card on file and consent for charges for late cancel/no-show appointments and any appointments not covered by my insurance. I understand that the same policies regarding late cancel/no-shows apply to telehealth. I agree to ensure that a computer or device will be available and in working order at the time of my appointment.

I have read and understand the information provided above. I have discussed it with my therapist, and all of my questions have been answered to my satisfaction.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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