Angel House
Bereavement Center

Consent for Telehealth Sessions

1. I understand that my health care provider wishes me to engage in a Telehealth sessions.
2. My health care provider explained to me how the video conferencing technology that will be used for sessions will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a Telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the Telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I understand that my therapist is located in the United States, in the state of Florida.
7. I understand that different states within the United States, as well as other countries, have different regulations regarding Telehealth and will inform my therapist of any change in my location.
8. I understand that I have a right to withdraw consent at any time without affecting my right to future care or treatment.
9. I understand the laws that protect confidentiality within traditional in-person counseling also apply to Telehealth. As such, I understand that the information disclosed by me during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to known or suspected abuse of a child or elderly / disabled adult, and if I am known or suspected to be a danger to myself or others.

Consent:

Yes ☐ No ☐

Client's Signature _____ Date: _____

Parent/Guardian's Signature_____ Date: _____

Provider Signature_____Date:_____