



Ferren Family Counseling LLC

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## Consent for Telehealth Services

### Introduction

Telehealth is the delivery of healthcare services when the healthcare provider and client are not in the same physical location through the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or client education, and may include any of the following:

- Client health records.
- Interactive audio, video, and/or data communications.
- Output data from mental health devices and sound and video files.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

### Potential Benefits

1. Improved access to mental health care by enabling a client to remain in his/her residence or other site.
2. Efficient evaluation, treatment and management when travel is not appropriate or available.
3. Obtaining the expertise of a distant specialist.

### Potential Risks

As with any medical or mental health treatment, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images, poor internet connection) and may impact effective communication and decision-making made by the clinician and client(s).
2. The clinician is not able to provide emergency care through use of Telehealth equipment.
3. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal health information.

*Please initial after reading this page: \_\_\_\_\_*

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of health information also apply to Telehealth. No information obtained during a Telehealth encounter which identifies me will be disclosed to other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of Telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a Telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I may choose alternative care (in-office sessions or Telehealth sessions) at any time.
5. It is my responsibility to ensure Telehealth is a covered service of my insurance provider and plan, if I choose to utilize my insurance for Telehealth services.
6. I understand that it is my duty to inform my mental health clinician of electronic interactions regarding my care that I may have with other healthcare providers.
7. I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.

Client Consent to the Use of Telehealth

I have read and understand the information provided above regarding Telehealth, have discussed it with my mental health clinician, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my mental health care.

I hereby consent to and authorize FERREN FAMILY COUNSELING/\_\_\_\_\_ (*name of Clinician*) to use Telehealth in the course of my diagnosis and treatment.

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

If authorized signer, relationship to Client: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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

Clinician: \_\_\_\_\_

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

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