



## Telehealth Informed Consent

Given the current coronavirus outbreak, Daily Behavioral Health (DBH) is prepared to offer telehealth as an option, only if necessary, for our patients. Telehealth therapy with DBH providers will occur primarily through telephone conversations and/or secured video-based services and may involve email exchanges.

My signature below signifies my consent to engage in telehealth therapy with a service provider at DBH. Service providers may include psychologists, counselors, social workers, Board Certified Behavior Analysts (BCBA), and Speech Language Pathologists (SLP).

- Telehealth therapy with psychologists, counselors, or social workers includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth therapy may include behavioral health care delivery, diagnosis, consultation, and psychotherapeutic treatment.
- Telehealth therapy with BCBA's to provide Applied Behavioral Analysis (ABA) services includes behavioral consultation and remote supervision of behavior technicians.
- Telehealth therapy with SLPs includes the assessment, treatment, and consultation of a wide range of speech and language disorders.

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

1. I have the right to withhold or withdraw consent at any time. If consent is withheld or withdrawn, I may have the option to speak with the service provider to request a referral to another community service provider.
2. I understand that telehealth may not be as complete as face-to-face services. The use of telehealth therapy is subject to the discretion of DBH service providers, is temporary in nature, and based upon the assessment of a client's clinical needs. You and your service provider will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology. Face-to-face behavioral health sessions will resume after the necessity for the temporary telehealth sessions has passed.
3. Receiving telehealth therapy may be contraindicated with:
  - recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)
  - moderate to severe major depression or bipolar disorder symptoms
  - moderate to severe substance abuse or dependence symptoms
  - severe eating disorders
  - a clinical presentation with severe physical symptoms that requires medical attention
  - repeated "acute" crises (e.g., occurring once a month or more frequently)
4. Telehealth services delivered by my therapist are required by law to take place within the state of Ohio. If I am physically located outside of the state of Ohio, I will immediately notify my therapist.
5. Telehealth therapy appointments occur at the time agreed upon between you and your provider. If you miss your scheduled appointment, you must contact your service provider.
6. It is my responsibility to confirm coverage of telehealth from my insurance and pay for any services not reimbursed by my insurance. I understand I may also be charged for missed appointments.
7. The laws that protect the confidentiality of your personal information and clinical treatment record also apply to telehealth therapy. As such, I understand that the information disclosed by me during the course of telehealth sessions is generally confidential. However, there are exceptions to confidentiality, including:
  - The client is in imminent danger of harm to self or others and it is necessary to ensure the client's and/or other's safety.
  - The provider has reason to suspect the presence of abuse or neglect of a child, an elderly person, or dependent adult; and must make a mandatory report to Child and Family Services.



- A DBH service provider is presented with a valid court order.
  - The client is a minor and information is requested by their parent or guardian.
8. I agree not to record telehealth sessions and must disclose to my service provider if anyone else is participating in or listening to the conversation. It is my responsibility to maintain privacy on the client-end of communication by ensuring the privacy of my location.
  9. I understand that my telehealth provider may not be available for contact between scheduled sessions.
  10. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that:
    - a. the transmission of my personal information could be disrupted or distorted by technical failures;
    - b. the transmission of my personal information could be interrupted by unauthorized persons; and/or
    - c. the electronic storage of my personal information could be accessed by unauthorized persons.
  11. I understand that I may benefit from telehealth therapy, but results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of therapy, and despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
  12. I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based telehealth therapy services.
    - a. I acknowledge that if I am in crisis or in an emergency I should immediately call 911 or seek help from a hospital or crisis orientation health care facility in my immediate area.
      - i. If understand that emergency situations include if I have thoughts about hurting or killing either myself or another person, if I have hallucinations, if I am in a life threatening or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs
    - b. I acknowledge that I have been told if I feel suicidal, I am to call the National Suicide Hotline (1-800-784-2433) or 911, or go to the closest psychiatric emergency room (closest to DBH is Fairview Hospital for children and adolescents, Lutheran Hospital for adults).
  13. I agree to provide a back-up phone number in case we are disconnected during our telehealth session. A back-up phone number is \_\_\_\_\_.
  14. The laws and professional standards that apply to in-person psychological, speech-language, and BCBA services also apply to telehealth services. My provider will continue to take notes and documentation of telehealth sessions similar to in-person sessions. I understand that this document does not replace other agreements, contracts, or documentation of informed consent.

I have read and understand the information provided above. By electronically signing this document I agree to follow these guidelines and expectations for telehealth services through Daily Behavioral Health.

**Please sign and email back to [office@dailybh.com](mailto:office@dailybh.com) or fax to 216-252-1409.**

\_\_\_\_\_  
Printed name of client

\_\_\_\_\_  
Signature of client or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of service provider

\_\_\_\_\_  
Date