Headway
Emotional Health

Informed Consent For Telehealth Services

Telehealth services are covered under the same privacy standards and rights as face-to-face, or in-office, sessions. Telehealth services involve the use of HIPAA compliant, live, two-way interaction between the client and provider using audio-visual technology for the delivery of mental health services to and from remote locations. These interactive systems are compliant with current privacy regulation.

By signing this consent form:

- I consent to receive outpatient mental health services by means of telehealth technology.
- I understand that I will not physically be in the same room as my telehealth provider.
- I understand that while the session is conducted via HIPAA compliant software, factors in my own environment (others present, privacy of the location) may affect the confidentiality of my sessions. It is in my best interest to be in a location that is private and in which I can stay focused on my treatment during the appointment time.
- I understand that it is important to hold telehealth sessions in a safe and private environment that allows for focusing on my care. If my provider believes the environment is not safe or not private (ie. In a public place, operating a vehicle, multiple distractions, etc.) the session will be rescheduled.
- I will agree to provide my specific location and contact phone number at the start of each appointment.
- Should a session be interrupted or disconnected for any reason, I agree to wait for my provider to make contact to reconnect and will accept the call or invitation to rejoin the session. Failure to reconnect may result in notification of emergency services as necessary, dependent on the situation.
- I understand that all documentation and storage of my protected health information will take place in the electronic health record utilized by Headway.
- I understand that either my telehealth provider or I can discontinue the visit if the telehealth services are not adequate for my situation.
- I understand that I will be informed if individuals other than my telehealth provider are present in the room at the time of service, and appointments will be managed in a similar manner as in-clinic appointments.
- I understand that my provider can terminate telehealth therapy services if he/she determines that I would receive a greater benefit from in-clinic services. My provider will assist me in locating the appropriate resources and/ or making the transition to in-clinic services.

Client Name

Signature of Client/Parent/Legal Guardian Date