



*Lifeline Family Enrichment*

## **Client Telebehavioral Health Informed Consent Form**

*(Completion of this form is necessary to participate in Telebehavioral Therapy. Please read carefully as your signature indicates you have thoroughly read and understood the information contained in this document).*

### **Telebehavioral Health (TBH) Services Defined:**

I, \_\_\_\_\_, hereby consent to engage in TBH therapy with *Barbara Fountain dba Lifeline Family Enrichment Counseling*.

- Telebehavioral Health Therapy (TBH) is a form of psychological therapy provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications.
- I understand that TBH involves the communication of my medical/mental health information, both orally and/or visually. TBH has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person.
- However, due to the nature of the technology used, I understand that TBH may be experienced somewhat differently than face-to-face treatment sessions.
- I understand the interactive technologies used in TBH incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
- I understand the electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, imaging data, and will

include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

**Client's Rights, Risks, and Responsibilities:**

- I understand, as the client, I have the right to withhold or withdraw this consent for TBH treatment at any time without affecting my right to future care or treatment.
- I understand the laws that protect the confidentiality of my medical information also apply to TBH therapy.
- As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the **LFE Confidentiality Statement Form** I received at the start of my treatment with **Lifeline Family Enrichment Counseling**.
- I understand that there are risks and consequences of participating in TBH therapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures.
- I understand these services rely on technology, which allows for greater convenience in service delivery. I acknowledge there are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality.
- I understand my therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

**Disruption of Service:**

- I understand that should service be disrupted during a session, my therapist will contact me by phone or email to reschedule my session unless the disruption occurred within the last fifteen minutes of the session.

**Laws & Standards:**

- I understand the laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

**Confirmation of Agreement:** *(By signing below, I confirm that I understand and agree to the statements above)*

\_\_\_\_\_  
**Client Printed Name**

X \_\_\_\_\_

**Signature of Client or Legal Guardian**

\_\_\_\_\_, 2020

**Date**

\_\_\_\_\_  
**Printed Name of Therapist/Practitioner**

X \_\_\_\_\_

**Signature of Therapist/Practitioner**

\_\_\_\_\_, 2020

**Date**