R.E.A.C.H.

Reaching Educational Achievements with Clinical Mental Health

Located at Conemaugh Township Area Middle School/High School
300 West Campus Ave
Davidsville, PA 15928

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Child's Name:		
DOB:	Grade:	Homeroom Teacher:
Child's Email:		Clinician:

I understand I have the following rights under this agreement with R.E.A.C.H.:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. I agree that certain situations including emergencies and crises are inappropriate for telehealth psychotherapy services (audio/video/computer-based services). If I am in crisis or in an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility.

All telehealth services will be provided over a HIPAA compliant program. I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of my Licensed Professional Counselor or Licensed Eligible Professional Counselor, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons.

I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to using telehealth communications at any time.

My signature below indicates that I have read this Agreement and agree to its terms.

Informed consent for telehealth services was reviewed and verbal consent was obtained from the client

on _____.

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date

_____ _____

Witness Signature Date