

# Footsteps Counseling Telemedicine Informed Consent Form

I \_\_\_\_\_ (patient's name) hereby consent to engaging in telemedicine as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Because of recent advances in communication technology, the field of tele-therapy has evolved. It has allowed individuals who may not have local access to a mental health professional to use electronic means to receive services. Because it is relatively new, there is not a lot of research indicating that it is an effective means of receiving therapy. An important part of therapy is sitting face to face with an individual, where non-verbal communication (body signals) are readily available to both therapist and client. What is important here is that you are aware that tele-therapy may or may not be as effective as in-person therapy and therefore we must pay close attention to your progress and periodically evaluate the effectiveness of this form of therapy.

The counseling services you are receiving is from a Footsteps Counseling office and therefore are bound by the laws of the State of Virginia. These laws are primarily related to confidentiality as outlined in this form and on the treatment consent form.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area or come in to a Footsteps office. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.

(6) This telehealth consent is an ADDITIONAL consent to your treatment consent (not a replacement). All Footsteps Counseling policies apply to telehealth services.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature of patient/parent/guardian. If signed by other than patient indicate relationship

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date