WELLSPRING

THERAPYCENTER

4301 West 57th Street Suite 100, Sioux Falls, SD 57108 605-335-1516

Telemental Health Informed Consent

I understand and agree to receive telemental health services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential challenges of telemental health, which may include the following:

1. The video connection may not work or may drop during the session.
2. The video or audio transmission may not be clear.
3. I may be asked to go to my therapist's office in person if it is determined that telemental health is not an appropriate method of treatment for me.

I recognize the benefits of telemental health, which may include the following:

1. Reduced cost and time commitment for treatment due to the elimination of travel.
2. Ability to receive services near my home or from my home.
3. Access to services that are not available in my geographic area.

I give my consent to engage in psychotherapy via video conferencing. I understand that my therapist uses HIPAA compliant technology to transmit and receive video and audio and stores all notes and information related to my treatment in a manner that is compliant with state and federal laws. I understand that it is my responsibility to ensure that my physical location during video conferencing is free of other people to ensure my confidentiality. Furthermore, I understand recording my sessions is prohibited.

I understand I have the the option to request in-person treatment at any time, and my therapist will schedule this or make a referral if travel to the therapist's office is not possible. I understand that, depending on my location, closer providers may not be available.

I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

I understand billing and payment for these services is similarto in person treatment.

My signature indicates I agree to participate in telemental health under the conditions in this document.

Client name (please print): _____

Legal guardian (if applicable): _____ Relationship to client:_____

Client/Guardian signature:_____ Date: _____/_____/_____