Inclusivity Clinical Consulting Services

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Telehealth Informed Consent Form

According to the American Psychological Association (2013), telepsychology is defined as "the provision of psychological services using telecommunication technologies. Telecommunications is the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means (Committee on National Security Systems, 2010). Telecommunication technologies include but are not limited to telephone, mobile devices, interactive videoconferencing, e-mail, chat, text, and Internet (e.g., self-help websites, blogs, and social media). The information that is transmitted may be in writing or include images, sounds, or other data. These communications may be synchronous, with multiple parties communicating in real time (e.g., interactive videoconferencing, telephone), or asynchronous (e.g., e-mail, online bulletin boards, storing and forwarding of information). Technologies may augment traditional in-person services (e.g., psychoeducational materials posted online after an in-person therapy session) or be used as stand-alone services (e.g., therapy or leadership development provided over videoconferencing)."

I, ___________________________________ (client name), hereby consent to engaging in telehealth with ______________________________________ (Psychologist name) as part of my treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications within the state of California. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California with my consent.

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

(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 telehealth. 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 expectations 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 if I am in such mental or emotional condition to be a danger to myself, my psychologist has the right to break confidentiality to prevent the threatened danger.

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

(3) 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 psychologist, that: the transmissions 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 telehealth based services and care may not be as complete as face-to-face service. I also understand that if my psychologist believes I would be better served by another form of psychological treatment services (e.g. face-to-face services) I will be referred to a psychologist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my psychologist, my condition may not be improved, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, 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 California law.

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

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Date/Signature of patient/parent/guardian/conservator (if signed by other patient indicate relationship)

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Date/Signature of psychologist

Complaints

If you have a concern or complaint about your treatment, please talk with us about it. We will take your feedback seriously and respond with respect. If you believe that we have been unwilling to listen and respond, or that we have behaved unethically, you can contact the Board of Behavioral Science Examiners, which oversees licensing, and they will review the services we have provided.

Board of Psychology
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References

American Psychological Association (2013). Guidelines for the Practice of Telepsychology. Retrieved from https://www.apa.org/pubs/journals/features/amp-a0035001.pdf.

Committee on National Security Systems. (2010). National information assurance (IA) glossary. Retrieved from https://www.cnss.gov/Assets/ pdf/cnssi_4009.pdf.