Transformation Behavioral Health, LLC

Tele-Mental Health Inform Consent

Client's Name: _____ DOB: _____

1. I understand my mental health provider wishes me to engage in telemental health counseling sessions.

2. I understand my mental health provider will only use a HIPPA compliant platform to conduct telemental health counseling sessions.

3. My mental health provider explained how the video conferencing technology that will be used to affect such a counseling session in that we will not be the same as a direct client/therapist contact due to the fact of not being in the same room.

4. I understand telemental health has counseling session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

5. I understand there are risk to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my mental health provider or I can discontinue the telemental health sessions if it is felt that the video conferencing is not adequate for the situation.

6. I have had direct conversation with my mental health provider during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and practical alternatives have been discussed with me in a language in which I understand.

By signing below I am agreeing that I have read, understood and agree to the items in this telemental health informed consent.

_____ _____

Client's Signature (must be 18 years old) **Date**