Bridges and Pathways Counseling Services
Twin Cities

INFORMED CONSENT FOR TELEMEDICINE SERVICES

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

1. I understand I have the following rights under this agreement: I have a right to confidentiality with Telemedicine 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 generally 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.

2. 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.

3. Further, I understand that the dissemination of any personally identifiable images or information from the Telemedicine interaction, to any other entities shall not occur without my written consent.

4. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telemedicine, results cannot be guaranteed or assured.

5. I further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that our therapy sessions regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

6. I understand that I may benefit from telemedicine services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, and Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems.

Consenting to the information in this form shows an awareness of these issues, and a decision by this client to use these systems for telemedicine services.

I will not hold Bridges and Pathways Counseling Services, Inc. or its' staff liable for gathering or use of client information by these service providers.

7. In addition, I understand that Telemedicine treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in person treatment, I will be referred to a therapist in my geographic area that can provide such services.

8. 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.

9. I understand that I can withdraw my consent to Telemedicine communications by providing written notification to my therapist at the address listed.

My signature below indicates that I have read the Telemedicine Policies and Procedures and the above Informed Consent to Telemedicine and agree to its terms.

Client Name:_____

Client Signature:_____
(Signature of Parent, Guardian, or Authorized Representative if a Minor)

Date:_____

Therapist Signature:_____

Date:_____