INDEPENDENCE CENTER
inspiring lives with dignity and purpose

Independence Center – Telehealth Informed Consent

Name:	

I agree to participate as a patient in a telehealth delivery system. I will be receiving mental health services through an interactive videoconferencing software that is secure and HIPAA compliant. I understand that videoconferencing is an alternative method of mental health care delivery and that my provider will not be physically in the same room with me.

I understand that although my provider makes every effort to protect my privacy by using a secure server, they cannot guarantee the security of any information transmitted over the internet. By using telehealth services, I recognize that transmissions over the internet are at my own risk and that third parties may unlawfully intercept of access the transmissions. I also understand that despite reasonable efforts on the part of my provider, there are risks and consequences in using telehealth services. The risks include, but are not limited to, the possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, Independence Center will make every effort to reconnect me to the session.

I also understand that telehealth services may not be as complete as services provided via face-to-face, although several benefits of telehealth services have been identified including increased access to specialized care and decreased waiting times for services. I have also been notified that if my provider believes I would be better serves by another form of provider services, I will be referred to a provider who can provide such services. Finally, I understand that there are potential risks and benefits associated with any form of mental health services and that, despite my efforts and the efforts of my provider, my condition may not improve and in some cases may even get worse. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time. My privacy and confidentiality will be protected.

I understand that there will be no recordings of visits with my provider. I also agree to not record my own visits without my provider's knowledge or permission.

I understand that the telehealth services will be provided to me free of charge and cost the same as an in-person appointment.

I give my consent to receive mental health services through the telehealth system. I also understand that the services I receive will become a part of the record at Independence Center.

Signature Date:	
Electronic Signature:	