



TELEHEALTH INFORMED CONSENT

This Informed Consent form is intended to inform you about **Heartland's** policy and procedure regarding Telehealth Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, have acknowledged that you understand and agree that your Heartland clinician will provide therapy to you according to this Telehealth Informed Consent agreement. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telehealth services. This policy can be available at any time if requested.

I understand that Telehealth (also referred to as e-therapy, teletherapy, telementalhealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telehealth. My rights to confidentiality with Telehealth services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. These limits are outlined in Heartland's Terms of Care and Consent form, which is signed by all clients prior to treatment.

Therapeutic treatment for mental health, both in person and through Telehealth services, has been found to be effective in treating a wide range of clients, though, individual results and responses to Telehealth may vary. By signing this form, I also understand that results of Teletherapy cannot be guaranteed.

I further understand that there are risks unique and specific to Telehealth, including but not limited to the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, please contact Heartland at 515-331-0303 for assistance.

I understand that Telehealth treatment for mental health is different from in-person therapy. I understand that if my therapist believes I would be better served by another form of therapeutic treatment or services, such as in-person treatment, I will be provided a referral to another therapist who can provide me with recommended services, such as in person therapy.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telehealth

interaction to any other entities **shall not occur without my explicit written consent.** Heartland clinicians also agree to under no circumstances take any personally identifiable images from the session or store any of these images on their own devices from Telemedicine sessions.

I also understand that my Telehealth appointment time is reserved exclusively for me. If I cannot attend my scheduled appointment, I will contact Heartland directly at least 24 hours before the session start time to reschedule. **If I do not provide 24-hour notice for non-emergency reasons, a late cancellation fee will apply.** In accordance with our Heartland Christian Counseling Terms of Care and Consent form, if you are unable to attend a scheduled appointment, you will be expected to pay a **\$50.00** late cancellation fee unless you provide a 24 hours advance notice of cancellation (or unless your clinician agrees you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Also, due to current licensing and insurance requirements, I agree to be physically in Iowa for each telehealth session.

I understand that Telehealth appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one present in the room. I also agree to be connected to my Telehealth session through a reliable device and internet connection.

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telehealth services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Heartland Christian Counseling at 515-331-0303 or on our website at www.heartland-christiancounseling.com.

I understand I have the right to discuss any of this information with my clinician and to ask any questions I may have regarding my treatment through Telehealth services. My signature below indicates that I have read this Telehealth Informed Consent and agree to its terms.

Client Name (printed): _____
(or parent or legal guardian)

Client signature: _____
(or parent or legal guardian)

Witness: _____
Date (mm/dd/yy): _____