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Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth is the use of electronic communications to allow you/your child to continue to receive mental health services by interactive video (phone/computer/tablet) and/or auditory (phone only) devices.

Although you have previously signed acknowledgment of HIPAA (confidentiality) requirements, we must tell you that services provided by video or telephone are not as secure as services provided in-person. There is a greater risk that your personal information can be seen or heard if we talk by video or phone, than would be if we were face-to-face. We will still take every possible precaution to protect your privacy. We will only use a HIPAA compliant video platform. We will not record telehealth sessions.

By signing this form, I give permission for myself/my child, _____
 (print name)

to receive mental health services including assessment, diagnosis, treatment and psychoeducation using either video or audio communications.

My signature also indicates that I understand the following:

1. I have the right to withdraw my consent for telehealth services at any time.
2. I will need a mobile "smart" phone, tablet or computer with adequate data limits, WiFi or internet service to access video telehealth services. A landline or "flip" phone will work for telephonic (non-video) services only.
3. There may be disruptions in sessions due to technical failures of equipment and/or mobile phone or internet service providers that are beyond the provider's control.
4. Telehealth services and care will be different from face-to-face sessions, but are offered as a way to continue treatment while in-person services are not available.
5. Telehealth sessions will be documented and billed to my insurance in the same way that face-to-face services are. I am responsible for paying the co-payment required by my insurance carrier.
6. Telehealth services are not "on-call" and will be scheduled by the provider or office staff.
7. In the event of a mental health crisis or emergency, I can contact the Marshy Hope Family Services therapist on call at 443-521-3273 or the Eastern Shore Operations Center (Mobile Crisis Team – 1-888-407-8018) or 9-1-1.

My signature below means that I have read, understood and agreed to the information provided in this document.

_____	_____	_____
Print Name	Signature	Date
_____	_____	
Therapist Signature	Date	

_____ By initialing here, the therapist is indicating that the above was explained verbally to the client/guardian because face-to-face interaction was not possible.