



Telehealth Informed Consent Form

I (print name) _____ consent to engaging in telehealth with Life Skills Learning Center as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning and therapy. Telehealth will occur primarily through Interactive audio, video, telephone and/or audio/video communications.

I understand I have the following rights with respect to telehealth:

- 1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
- 2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
- 3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Life Skills Learning Center that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my counselor believes I would be better served by other interventions I will be referred to a mental health profession who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my counselor, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of ZOOM video-conferencing is HIPPA compliant, but that may have issues with Wi-Fi connectivity. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my counselor, and all of my questions regarding the above matters have been answered to my approval.

6) I understand If I chose to utilize Life Skills Learning Center homebased telehealth services, continuation of this service is at the discretion of the counselor in that it is conducive to the delivery of value-added, quality, up to 60 minute sessions. Factors that influence the success and continued delivery of homebased telehealth services include, but are not limited to: level of distractions within my home, my internet connectivity (dependability/speed) and my equipment (charged phone, computer, microphone/ camera quality). I understand my counselor will determine if he/she believes I would be better served by accessing services through the main office, and will discuss this with me as deemed necessary.

I further understand that I must be PHYSICALLY PRESENT within the state of NEW MEXICO to engage in telehealth services with Life Skills Learning Center.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, I am in a life threatening or emergency situation, and/or I am abusing drugs or alcohol and am not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

Client Signature or Guardian

Date

LSLC Staff

Date