Healing connections Therapy Center

PHONE: 952-892-7690
FAX: 952-898-4930
1751 Southcross Drive West
Burnsville, Minnesota 55306

Consent for Telehealth:

I understand that I need to be a resident of Minnesota and be in the state of Minnesota at the time of the session in order to receive telehealth services through Healing Connections Therapy Center.

Benefits

Tele-health services may improve my access to behavioral health services when either myself or my provider are unable to meet face-to-face.

Risk

Telehealth services are not the same as meeting with my provider face-to-face and certain information may not be able to be assessed by my provider via telehealth. I understand there could be technical problems including video quality, audio quality or Internet connectivity.

Confidentiality

I understand that the software being used to provide tele-health meets the recommended standard to protect the privacy and security of tele-health sessions. However, Healing Connections Therapy Center cannot guarantee the total protection against hacking or tapping into the tele-health session by an outsider.

Rights

I understand I have the right to withdraw or withhold my consent at any time to tele-health without affecting my right to care in the future or withdrawal from programming I am otherwise entitled to.

The laws that protect confidentiality of my medical information also apply to telehealth. As such I understand that information disclosed by me during the course of my treatment via tele-health is generally confidential. Limits to this confidentiality includes mandatory reporting of abuse of children or vulnerable adults, expressed threats of violence towards a known victim or when the client's emotional or mental state presents a danger to their personal safety, or as court ordered. I have the right to be informed by my provider if any other professional can see or hear part of our session.

Responsibilities:

- I will not record any of the telehealth sessions and I understand my provider will not record any of our telehealth sessions.
- I will notify my provider if any other person can hear or see part of our session before the beginning of our session.
- I understand that I am responsible for the configuration and understanding of any electronic equipment or devices I may use for telehealth.
- I understand that I will be using my own equipment to communicate with my provider and not equipment owned by another person or entity. I am aware that if I use my employer's computer or devices all information exchanged may be considered by the courts to belong to my employer and thus compromise my confidentiality and privacy.
- I hereby consent to engage in telehealth with Healing Connections Therapy Center as part of my mental health evaluation and treatment. I understand that telehealth includes the practice of health care delivery diagnosis, education and treatment using interactive audio and video communications. I have read and understand the information provided above regarding telehealth and agree to receive telehealth services from Healing Connections Therapy Center.

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Client Name

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Client Signature Date

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Parent or Guardian Signature (if required)