



Kindred Counseling Center

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Philadelphia

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Telehealth Informed Consent Form

The purpose of this form is to obtain your consent to participate in telehealth services with **Kindred Counseling Center**.

A Telehealth session is similar to a routine outpatient therapy office visit, except interactive video technology allows you to communicate with your therapist at a distance. Just like with in-office visits, your therapist will perform a safety assessment and make recommendations for a higher level of care or crisis services when needed.

- 1) Purpose and Benefits: I understand that the telehealth platform allows access to mental health services that might not otherwise be available to me due to my physical health, geographic limitations or other factors. I understand that it is up to the **Kindred Counseling Center** provider's discretion to determine whether I, or my child, would be eligible to participate in and would benefit from telehealth services.
- 2) Nature of Services: I understand that telehealth appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.
- 3) Technology: I understand that I will need to download an application and/or software to use this service. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact my therapist at **Kindred Counseling Center** via phone to coordinate alternative methods of treatment.
- 4) Confidentiality: I understand that all existing laws regarding my access to medical information and copies of my medical records apply to the telehealth services. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth services. The laws that protect the confidentiality of my medical information also apply to the telehealth services. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. The telehealth platform used by **Kindred Counseling Center** providers is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Informed Consent, which I have signed.
- 5) Rights: I understand that I have the right to withdraw my consent to telehealth services at any time. I understand that I have a right to access my mental health information and copies of medical records in accordance with PA state law.

6) Risks: I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my therapist, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I understand that my therapist at **Kindred Counseling Center** cannot provide telehealth services to me if I am outside of the State of Pennsylvania.

7) Financial Agreement: I understand that telehealth services may be covered by my health insurance plan. I understand that I am responsible for all telehealth fees. Fees associated with telehealth appointments are payable by credit or debit card only and at the end of the session. If my card is declined, I agree to provide alternative card information to my therapist immediately after my telehealth session.

Clients using out-of-network insurance reimbursement:

I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I understand that my individual insurance plan may not offer telehealth coverage even if it covers regular outpatient in-office visits. I understand that I am responsible for paying session fees in full at the time of service.

Self-Pay clients:

I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment.

8) Scheduling and Cancellation policy: I understand that scheduling is based on my provider's regular office hours. 24-hour cancellation is required for all telehealth appointments. I understand that I will be charged in accordance with the cancellation policy for all no-shows and late cancellations.

9) Video/Audio Recording: As a general practice **Kindred Counseling Center** DOES NOT record Telehealth sessions without prior permission.

My signature below indicates that I have read and understand the information provided above. I have been advised of all the potential risks, consequences and benefits of telehealth. I have discussed it with my therapist and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____ Printed Name (Client or Parent/Guardian)	_____ Signature of Client	_____ Date
_____ Printed Name, Age (Minor)	_____ Signature of Minor	_____ Date

This is a strictly confidential client record. Redisclosure or transfer is expressly prohibited by law.