Consent for Telehealth Treatment

My signature below acknowledges that I, (print name)_____, consent to telehealth treatment with my clinician _____, who agrees to provide me with competent professional care and to do their best to be of help to me.

Standards

Telehealth services are held to the same ethical and legal standards as in-person sessions. This document serves as an addendum to, not a replacement for, our in-office service agreements and consent for treatment.

I acknowledge that I am receiving services provided under a license issued by and limited to practice in the State of Maryland. I agree to affirm at the beginning of each session that I am located in the State of Maryland at the beginning of and for the duration of the telehealth session.

Emergencies

If an emergency should occur during a telehealth session, my provider may consider taking any steps necessary to ensure my safety or the safety of others.

If any emergency arises, including a mental health emergency, I should call 911.

Technology and Connection

I understand that telehealth services require that I provide a confidential space of my choosing in which the session will not be interrupted. By signing this agreement, I am indicating that I am comfortable with the technology needed to render the service.

I agree to be prepared at the time of my scheduled appointment for my provider to initiate the telehealth session. This includes being in an area with reliable signal or internet connection and having a charger or sufficient power supply to prevent interruptions.

I am responsible for providing an internet connection for my computer or a data connection for my mobile device. I understand that telehealth service delivery requires a live-streaming video connection that may affect my internet service or data service plan limits, if applicable. I hold free from liability The Resource Group/Resource Connect and/or my affiliate clinician from any effect telehealth may have on my service plan limits.

Confidentiality and Security

I understand that my clinician will be in a confidential space free from interruption. During telehealth treatment we will discuss confidential, HIPAA-protected treatment information over a secure video streaming platform with whom my clinician has signed a Business Associate Agreement per HIPAA guidelines.

Mental health and/or substance abuse treatment is a collaboration between my clinician and me. I and my provider both agree to not record telehealth sessions without the express prior written consent of both parties.

Scheduling and Payment

By scheduling an appointment with my provider, I am conferring on Resource Group the responsibility to commit the resources necessary for my session to the time of my appointment. I agree to leave a debit or credit card on file to pay my clinician at the time of telehealth service delivery. I may leave a healthcare payment card on file for patient responsibility payments, but I must also leave a debit or credit card on file to cover missed appointments.

I will give at least 24-hours' notice if I must miss a telehealth session. I also agree to notify my clinician if I decide to terminate treatment. I understand that all late arrivals, missed appointments, or late cancellations are treated the same as and subject to the same fees as in-office services.

Communication

I give permission for all persons acting on behalf of RG/RC to contact me and leave messages at the following address, phone number, or email address. I understand that electronic communication brings potential risks that the information transmitted could be intercepted by a third party.

To change this permission, I must contact RG/RC in writing and let them know that I no longer consent to telehealth treatment. My contact info is below:

Client Printed Name: _____

Address: _____

Phone: (H) _____ (C) _____

Email: _____

I have read this document and understand the above information.

_____ _____
Client Signature (14 and over) Date

_____ _____
Parent/Legal Guardian Signature Date
(for clients under age 18)