Client Name:_____ DOB: _____

Sexual Assault Center
101 French Landing Dr.
Nashville, TN 37228

INFORMED CONSENT AND AGREEMENT FOR TELEHEALTH SESSIONS

**Definition of Telehealth:** Telehealth involves the use of electronic communications to enable Sexual Assault Center therapists to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of mental health care delivery, diagnosis, consultation, treatment, and referral to resources, education, and the transfer of clinical data.

1. I understand that my participation in telehealth sessions is completely voluntary, and that my decision to participate or not participate in telehealth sessions in no way impacts my access to in-person therapy services once regular business resumes at the Sexual Assault Center. I also understand that I can change my mind at any time, and withdraw my consent for telehealth at any time during the course of my therapy.

2. I understand that this agreement applies only to a need for remote access to therapy, and is time restricted. Telehealth sessions are not an option for regular therapy sessions as normal practice at the Sexual Assault Center.

3. I understand that telehealth, using live video and audio communication, may not have the same impact as therapy sessions taking place in the same room as my therapist. Regardless of the sophistication of today's technology, some information my therapist would ordinarily get in in-person therapy sessions may not be available in telehealth, and may limit my therapist's ability to understand my current challenges. Additionally, I understand that telehealth may limit the types of interventions my therapist is able to utilize.

4. I understand that a telehealth session has potential benefits including access to therapy while I cannot meet my therapist in person, and the convenience of meeting from a location of my choosing.

5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist will take all reasonable precautions to ensure privacy and confidentiality during telehealth sessions, and that I am responsible for my own privacy during telehealth sessions.

6. I understand that my therapist or I can discontinue the telehealth session if it is felt that telehealth is not adequate for the situation.

7. My therapist and I will regularly discuss if telehealth sessions are the best way to continue to address my therapy needs while we are unable to meet in person, and modify our plan as needed.

8. The laws and professional standards that apply to in-person therapy services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

9. My therapist may be unable to provide the same kind of emergency assistance using telehealth, as in an in-person session. I understand that if I share information during telehealth session with my therapist that indicates an immediate safety concern, and I do not reasonably safety plan with my therapist, or my therapist is not assured of my safety, my therapist may need to call Mobile Crisis or 911 on my behalf.

10. I have the opportunity to ask questions about this procedure should I need. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE ZOOM TELEHEALTH

Zoom is the technology service we may use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Zoom is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Zoom, Zoom does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Zoom facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client/Guardian Signature Date

_____ _____

Therapist Signature Date