

Attachment Center LLC  
(d/b/a Fractured Hearts Counseling)  
18890 Rd 89, Cecil Ohio 45821 Phone:260-667-3807

## TELEHEALTH INFORMED CONSENT

I \_\_\_\_\_ (patient name) hereby consent to engaging in telehealth at Attachment Center, LLC as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the state of Ohio.

**Technology:** I understand that I am responsible for:

1. Having a broadband internet connection or a smart phone device with a good cellular/internet connection.
2. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions.
3. Providing the clinician my full name and date of birth to confirm my identity at the beginning of each session.
4. Providing the clinician the address of my location and the phone number I can be contacted at.

I also understand that in case of technology failure, I may contact Attachment Center, LLC via phone at 260-667-3807 to coordinate alternative methods of treatment.

**Potential Risks:** In rare cases, information transmitted may not be of sufficient quality (poor audio or video quality) to ensure the therapeutic benefits of your session. In rare cases, there could be delays in treatment due to deficiencies or failures of the equipment. In very rare instances, security protocols could fail, causing a breach of privacy or confidentiality

**Your Rights:** Your participation in telehealth is completely voluntary, and you have the right to withdraw your consent to use the use of telehealth at any time. Your rights to privacy and confidentiality are the same with telehealth as they are with face-to face treatment visits. All rules and regulations which apply to the practice of behavioral health treatment in the State of Ohio also apply to the use of telehealth.

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

1. I have the right to withdraw my consent at any time without affecting my right to future care or treatment.
2. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video/audio conferencing technology. 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 counselor/therapist/clinical intern, 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 at my request or the direction of my counselor/therapist/clinical intern, I may be referred to another form of psychotherapeutic services (e.g. face-to-face services) who can provide such services in my geographic area.

3. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
4. I understand that Attachment Center LLC may not provide telehealth services to me if I am outside of the State of Ohio, and I understand that I may access telehealth services from Attachment Center LLC from within the State of Ohio only.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with Ohio state law. I have read and understand the information provided above. I understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

My signature below indicates my informed and willful consent to treatment using this platform.

A photocopy of this consent form is to be considered as valid as the original.

PLEASE SIGN \_\_\_\_\_

Print Patient Name Date \_\_\_\_\_

Patient or Personal Representative's Signature Date \_\_\_\_\_

If Personal Representative, print name and describe relationship \_\_\_\_\_