



## Tele-Mental Health Inform Consent

**Beneficiary's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

1. I understand my mental health provider wishes me to engage in telemental health counseling sessions.
2. I understand my mental health provider will only use a HIPPA compliant platform to conduct telemental health counseling sessions.
3. My mental health provider explained how the video conferencing technology that will be used to affect such a counseling session in that we will not be the same as a direct client/therapist contact due to the fact of not being in the same room.
4. I understand telemental health has counseling session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
5. I understand there are risk to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my mental health provider or I can discontinue the telemental health sessions if it is felt that the video conferencing is not adequate for the situation.
6. I have had direct conversation with my mental health provider during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and practical alternatives have been discussed with me in a language in which I understand.

**By signing below I am agreeing that I have read, understood and agree to the items in this telemental health informed consent.**

\_\_\_\_\_  
**Beneficiary's Signature (must be 18 years old)**

\_\_\_\_\_  
**Date**