



# RIVER VALLEY BEHAVIORAL HEALTH & WELLNESS CENTER, LLC

## Informed Consent for Telehealth Sessions

Telehealth allows my provider to diagnose, consult, treat, and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participate in psychotherapy and or medication management services via the internet (hereinafter referred to as telehealth) with the clinician listed below:

Client: \_\_\_\_\_ Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
Name & Relationship Phone Number

I understand I have the following rights under this agreement:

- I have the right to confidentiality with telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy or medication management. Any information disclosed by me during the course of my session is generally confidential.
- There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and vulnerable adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent.
- I understand that while psychotherapy and medication management have been found to be effective in treating a wide range of mental disorders and personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured.
- River Valley utilizes secure and reliable HIPAA compliant platforms as their primary telehealth and virtual care communication. I understand that there are risks unique and specific to telehealth, including but not limited to, the possibility that our sessions or other communication by my provider to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. In the event of disconnection, the provider will call the client at the phone number listed above to discuss rectifying technical issues or rescheduling the session. Telehealth sessions are not permitted by phone only.

8640 Eagle Creek Circle, Savage, MN 55378  
Phone: 952-746-7664 Fax: 952-224-4867

Revised 5/8/2020

- I understand that telehealth treatment is different from in-person therapy and medication management and that if my provider believes I would be better served by another form of psychotherapeutic or medication management services, such as in-person treatment, I will be referred to a provider in my geographic area for such services.
- I understand that some parts of the examination involving physical tests for medication services cannot be conducted during a telehealth session, and my provider may direct me to have these tests conducted by a professional at my location.
- I accept that telehealth does not provide emergency services. During our first Telehealth session, my provider will discuss an emergency response plan, which will include contacting the listed emergency contact and/or 911 for the address listed. If I am experiencing an emergency situation, I understand I can call 911 or proceed to the nearest hospital emergency room. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.
- I understand I am responsible for 1) providing the necessary computer, telecommunications equipment, and internet access for my telehealth sessions; 2) maintaining the information security on my computer; and 3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.
- I understand that it is my responsibility as the client to call my insurance company and ask if the benefits under my plan cover telehealth and telemedicine sessions.

I have read and understand the information provided above. I have the right to discuss any of this information with my provider and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to telehealth communications by providing written notification to River Valley Behavioral Health & Wellness Center. My signature below indicates that I have read this Agreement and agree to its terms.

\_\_\_\_\_

Client (or Guardian) Signature

\_\_\_\_\_

Date