The Clinic for Mental Health and Wellness

502 S. 4th Street, Laramie, WY 82070
Phone: 307-755-1000 / Fax: 307 742-9717

TELEHEALTH CONSENT FORM

At this time, The Clinic for Mental Health & Wellness may offer to conduct sessions via telehealth service. Telehealth service is the delivery of healthcare services when the provider and client are not in the same physical location/site. The provider accesses the service through a secure telehealth software program. The clinic is using a HIPAA compliant telehealth site, Doxy.me for all telehealth appointments. The client may use various technologies such as a computer, tablet or smartphone to access the telehealth service. **To schedule or contact your therapist, please call the Clinic for Mental Health & Wellness at 307-755-1000.**

There are additional risks to telehealth compared to traditional counseling. We are using Doxy.me for all telehealth, which is a HIPAA compliant platform, allowing confidentiality with your provider. As with any technology, there is a chance of a security breach that would affect the privacy of personal and/or medical information. Second, since you will be completing sessions in your own home, we cannot guarantee the same level of privacy that you have when you are in our clinic. This means that you are responsible for making sure that you are in a private area where disruptions are minimized as much as possible. In order to reduce risks to confidentiality, we suggest that all video sessions occur in a private room with no one else present and that you wear headphones to limit the possibility of other people overhearing confidential information.

Since this may be different than the type of sessions with which you are familiar, it is important that you understand, acknowledge, and agree to the following statements: (Please Initial in yellow)

_____ **You understand that you (or your child) may engage in a telehealth encounter for yourself that will contain personal identifying information as well as protected health information.**

_____ **You understand that the therapist will be at a different location from you.**

_____ **You understand that you have the right to withhold or withdraw your consent to the use of telehealth services at any time in the course of your care, without affecting your right to future care or treatment.**

_____ **You have been informed of and accept the potential risks associated with telehealth.**

_____ **You understand that the laws that protect privacy and the confidentiality of medical information (HIPAA) also apply to telehealth, and that no information obtained in the use of telehealth which identifies you will be disclosed to other entities without your consent or as may be allowed by law.**

_____ **You have been given the opportunity to ask questions relative to your telehealth encounter, security practices, technical specifications, and other related risks.**

*****IN CASE OF EMERGENCY CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM******

By signing this form, you certify:
- That you have read or had read and/or had this form explained to you.
- That you fully understand its contents including the risks and benefits of telehealth services.
- That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

_____ _____
Client name (**PLEASE PRINT**) Date of Birth

_____ _____
Signature of Client/ Or Guardian Date

PLEASE PRINT E-MAIL/PHONE NUMBER: _____