ACORN COUNSELING LLC

109 West Wayne Street
Maumee, OH 43537
p. 419.893.8432 f. 419.891.5403
acorncounselingllc.com
info@acorncounselingllc.com

Telepsychotherapy Informed Consent

I, _____,[name of patient] hereby consent to engaging in telemedicine with _____ [name of psychotherapist] as part of my psychotherapy. I understand that "telepsychotherapy" includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that "telepsychotherpay" also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Ohio and outside of Ohio.

I understand that I have the following rights with respect to "telepsychotherpy":

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical/mental health information also apply to "telepsychotherpy". I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the "telepsychotherpy" interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from "telepshychotherapy", including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical/mental health information could be disrupted or distorted by technical failures; the transmission of my medical/mental health information could be interrupted by unauthorized persons; and/or the electronic storage of my medical/mental health information could be accessed by unauthorized persons. In addition, I understand that "telepsychotherapy" based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from "telepsychotherapy", but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Ohio law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client's E Signature_____ **Date**_____

Signature of Psychotherapist_____ **Date**_____