Stockbridge-Munsee Behavioral Health
Tele-Behavioral Health Informed Consent

Due to the COVID-19 outbreak, Stockbridge-Munsee Behavioral Health is offering telehealth psychotherapy sessions for the purpose of protecting the physical health of clients and staff members of the Behavioral Health Department.

I understand and agree to receive telehealth psychotherapy services from my therapist. This means that my therapist and I will, through a live interactive video connection, meet for scheduled psychotherapy sessions under the conditions outlined in this document.

I understand the potential risks of telehealth psychotherapy, which may include the following:
1) The video connection may not work
2) The video or audio transmission may not be clear
3) I may be asked to go to my therapist's office in person if it is determined that telehealth psychotherapy is not an appropriate method of treatment for me.

I give consent to engage in psychotherapy via video conferencing. I understand that my therapist uses HIPPA compliant technology to transmit and receive video and audio, and stores all notes and information related to my treatment in a manner that is compliant with current state and federal laws. I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality. Furthermore, I understand that recording my session is prohibited.

I agree to take full responsibility for the security of any communication of any communication or treatment on my own computer or electronic device in my own physical location. I understand that I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. **I understand that depending on my data plan, I may use cellular data that results in a higher phone bill.**

I understand and have the option to request in-person treatment at any time, and my therapist will assist in scheduling this. I understand the limitations to confidentiality with my therapist include reasonable belief that I am a danger to myself or others. I understand that, if my therapist reasonably believes that I plan to harm myself or someone else, my therapist will contact local emergency services to come to my location and ensure my safety.

My signature indicates that I agree to participation in telehealth psychotherapy under the conditions described in this document.

Client Name (please print) _____ **Date:** _____

Legal Guardian (if applicable) _____ **(relationship)** _____

Client/Guardian Signature: _____ **Date:** _____