A not-for-profit mental health center
15701 Crabbs Branch Way
Rockville, MDD 20855
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Teletherapy Informed Consent

Patient Name: ____ Date of Birth: ____________

Location of Patient: ____

Introduction

Teletherapy is the form of telemedicine that allows patients to access mental health care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to mental health care by enabling a patient to remain in his/her home or office.
- More efficient mental health evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the therapist and consultant(s);
- Delays in mental health evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;

Please initial after reading this page: __________

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy, and that no information obtained in the use of teletherapy which identifies me will be disclosed to anyone without my consent unless required by law.
2. I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time.
4. I understand that it is my duty to inform my therapist of any other healthcare providers involved in my medical/psychiatric care.
5. I understand that I may expect the anticipated benefits from the use of teletherapy in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Teletherapy

I have read and understand the information provided above regarding teletherapy. I hereby give my informed consent for the use of teletherapy in my medical care.

I hereby authorize Willow Oak Therapy to use tele therapy in the course of my diagnosis and treatment.

Signature of Patient (or person
authorized to sign for patient): ____________________________
Date: ____________________

If authorized signer, relationship to patient: ____

Witness: ________________________________ *Date:* ____________________

The mission of Willow Oak Therapy Center is to provide accessible and affordable mental health services to meet the individualized needs of each person.