Informed Consent for Telehealth Services

Definition of Telehealth: Telehealth involves the use of electronic communications to enable Dionne Aldridge, LCSW-C to connect with individuals using interactive video communications.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that the laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions 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 toward 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 telehealth interaction to other entities shall not occur without my written consent.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

I understand that, with my signed consent below, telehealth, mental health and wellness programs may also involve the communication of my mental health information, by texting, orally and visually, to other health care practitioners licensed in the State of Maryland.

Technology: I understand that I will need to go **to https://sessions.psychologytoday.com/dionne-aldridge** to begin my therapy session. I also understand that I need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Dionne Aldridge, LCSW-C via phone to coordinate alternative methods of treatment.

I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. CFS utilizes secure, encrypted audio/video transmission software to deliver telehealth

By signing this document below, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area

Telehealth Financial Obligations: Fees associated with Telehealth or wellness program appointments are payable by my insurance, credit or debit card. If fees may be associated with my Telehealth or wellness program services, I agree to pay for services prior to my scheduled Telehealth appointment via credit/debit card scheduled Telehealth appointment.

Client Consent to the Use of Telehealth: I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

I hereby consent to engaging in Telehealth, telemedicine and wellness program at Dionne Aldridge, LCSW-C as part of my psychotherapy and online counseling. I understand that "telehealth/telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, texting, and psychoeducation using interactive audio, video, or data communications.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____	_____
Print Name	Date
_____	_____
Client's Signature	Date

Please print, scan and email back to Info@InspiringMindsllc.com