Request to Use, Informed Consent & Agreement Regarding Use of Telehealth Services

Catholic Charities
DIOCESE OF SIOUX CITY

Client Name: _____

Date of Birth: _____

Requirement Information:

Entered With: Agency Placement

Actual Date: _____

Catholic Charities provides telehealth therapy services to individuals who are unable to participate in traditional face-to-face services because of difficulty with transportation, employment, significant medical or psychological difficulties, or being out of town for an extended period of time. Catholic Charities utilizes a HIPAA secured platform to provide therapy or psychiatric services to ensure confidentiality is protected as much as possible.

I, _____ (Client), hereby consent to engage in telehealth therapy services with Catholic Charities. I understand that these services could include assessment, consultation, treatment, telephone consultation, psychiatric, and education using interactive audio, video, or data communications. I understand that telehealth therapy also involves the communication of my mental health information, both orally and visually.

I understand the following regarding my use of telehealth services with Catholic Charities:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information disclosed by me during the course of services 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; or expressed threats of violence toward myself or another person.
3. I understand there are risks and consequences, including but not limited to, the possibility despite reasonable efforts on the part of Catholic Charities that: the transmission of my information could be disrupted or distorted by technical failures, the transmission in my information could be interrupted by unauthorized persons, and/or the discussion of my information could be overheard if not in a private setting.
4. I understand that I am responsible for providing the necessary computer/phone or equipment for the session and arranging an appropriate location that is free from distraction.
5. I understand that telehealth does not provide emergency services. My therapist and I will discuss an emergency response plan so that if I am experiencing an emergency situation I understand I can call 911, or go to a local hospital. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK or Catholic Charities 24-hour crisis line at 712-252-4547.
6. I understand that I am responsible for payment for my telehealth therapy and/or psychiatric sessions, and will make arrangements prior to starting services.

Additional Information/Signatures:

Client Signature:_____

Parent/Guardian's Signature: _____