



EDTC, LLC Informed Consent for Telehealth Services

I _____ (name of patient) hereby consent to engaging in telehealth sessions with _____ (name of clinician) as part of my treatment at the Eating Disorders Treatment Center, LLC.

I understand the following with respect to telehealth:

- My telehealth sessions will occur through interactive audio and video or through audio alone (such as over the telephone).
- The conditions in this *Informed Consent for Telehealth* are in addition to the conditions in the general *EDTC Informed Consent for Treatment* (e.g. my responsibilities for payment and cancellations/no shows, mandatory reporting, etc.).
- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment at EDTC.
- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by my therapist during the course of my sessions is confidential. However, all mandatory reporting exceptions outlined in the general *Informed Consent for EDTC* also apply to telehealth.
- There are potential risks and consequences from telehealth, including, but not limited to, the possibility that the transmission of my personal information could be disrupted or distorted by technical failures, or the transmission of my personal information could be interrupted by unauthorized persons.
- My clinician will conduct my telehealth session in a private room. In order to protect my privacy, I should find a quiet and private place within my home for the session.
- No permanent voice or video recording is kept of my telehealth sessions.
- Telehealth based services and care may not be as complete or as effective as face-to-face services, especially if there is a poor video and/or audio connection.
- If my clinician believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a mental health professional who can provide such services in my area.
- If my clinician becomes concerned about my safety before, during or after a telehealth session, she/he may contact my emergency contact and/or emergency services in my local area and dispatch them to my home.
- My insurance may not cover telehealth services and I am responsible for all charges incurred.



Eating Disorders
Treatment Center, LLC

To be completed by Clinician and Patient together:

Name of patient's emergency contact: _____

Telephone number of patient's emergency contact: _____

Local area crisis services name(s) and number(s): **1-855-NMCRISIS (662-7474)** _____

Telephone number my clinician should call to talk to me in the case of a disrupted telehealth session:

Patient Signature

Patient name (printed)

Date

Clinician Signature

Clinician name (Printed)

Date