Chart #:_____

Client Name:_____

Tele-Mental Health (Tele-Therapy) Informed Consent

I, _____, hereby consent to participate in Tele-Mental Health (Tele-Therapy) with, Nutley Family Service Bureau, Inc. , as part of my psychotherapy. I understand that Tele-Mental Health (Tele-Therapy) is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Tele-Mental Health (Tele-Therapy):
1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with Tele-Mental Health (Tele-Therapy) including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. NFSB, Inc., is taking all possible precautions to mitigate/minimize these risks.

3) I understand and agree that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Tele-Mental Health (Tele-Therapy) unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; if I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Tele-Mental Health (Tele-Therapy) services are not appropriate and a higher level of care is required. I understand that the NFSB Tele-Mental Health (Tele-Therapy) practitioner is bonded by law “Duty to Warn” (N.J Stat. Ann. 2A; 62A-16)

6) I understand that during a Tele-Mental Health (Tele-Therapy) session, we may encounter technical difficulties resulting in service interruptions. If this occurs, we will end and restart the session. If we are unable to reconnect within ten minutes, an NFSB representative should call me at this phone number: _____, to discuss a possible need to re-schedule.

7) I understand that my Tele-Mental Health (Tele-Therapy) practitioner may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

8) I understand that I must be in New Jersey in order to participate in telehealth with my clinician.

Emergency Protocols:

I understand that my Tele-Mental Health (Tele-Therapy) practitioner needs to know my location in case of an emergency. I agree to inform you of the address where I am at the beginning of each session. I understand you need a contact person who you may contact on my behalf in a life- threatening emergency only. This person will only be contacted to go to my location or to take me to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

This is my emergency contact's information:

Name:_____

Address:_____

Phone:_____

Relationship_____

If at the time of my Tele-Mental Health (Tele-Therapy) session, I am in a location different from the location noted here, I will provide such location at the beginning of the session.

I agree that all previous agreements/documents required by NFSB and signed by me, remain active and unchanged.

I have read the information provided above and discussed it with my Tele-mental Health (Tele-therapy) practitioner. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Signature of Client or parent/legal guardian (if client is under the age of 18). Date

☐ I agree that this agreement may be electronically signed. I agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

_____

Signature of Nutley Family Service Bureau Representative Date