



TELEHEALTH VIA VIDEO CONFERENCING AGREEMENT

The Family Center may provide mental health services through secure interactive video conferencing (“telehealth”), either instead of or in addition to in-person visits. Telehealth may be used when clinically appropriate and when permitted by applicable law.

Privacy & Confidentiality:

The Family Center uses a telehealth platform designed to meet applicable HIPAA privacy and security requirements. However, no electronic communication system can guarantee absolute privacy. Patients should participate from a private, quiet location and should notify the clinician if another person is present or able to hear the session. Patients may not record or screenshot sessions without the prior consent of the clinician and all participants.

Technology & Limitations:

Telehealth requires a reliable internet connection and functioning audio/video equipment. Technical difficulties may interrupt or delay a session. If the connection cannot be restored, the clinician may contact the patient by telephone or reschedule the appointment.

Patient Location:

The patient must provide their current physical location at the beginning of each telehealth session and notify the clinician if their location changes. Telehealth services can only be provided when permitted by applicable laws and licensing requirements in the location where the patient is physically present.

Emergency Situations:

Telehealth is not a substitute for emergency care. If you are experiencing an emergency or believe you may harm yourself or someone else, **call 911, go to the nearest emergency department, or call/text 988**. The Family Center may contact emergency services or other appropriate authorities when necessary to protect the patient or others. Patients should keep their emergency contact information current.

CONSENT TO TELEHEALTH

By signing below, I acknowledge that:

- ☐ I have read and understand this agreement and have had the opportunity to ask questions.
- ☐ I understand the potential benefits, risks, limitations, and privacy considerations of telehealth.
- ☐ I voluntarily consent to receive mental health services from The Family Center through telehealth when my clinician determines that telehealth is appropriate.

Patient/Parent/Legal Guardian Name: _____

Signature: _____ **Date:** _____