Ben Trelease, MA LMHC
Counseling for relationships

Telemedicine Informed Consent

Telemedicine: I understand that telemedicine includes mental health care delivery, diagnosis, consultation, treatment, and education using interactive audio, video, and/or data communications. The benefits of telemedicine may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

Confidentiality: The laws that protect the confidentiality of my personal information outlined in the Counseling Disclosure Statement also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy 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; imminent harm to myself or others; and court order.

Responsibilities: I agree to provide a working hardware system (e.g. computer, video camera and microphone) in order to connect with my therapist for telemedicine. I agree to download the HIPAA-compliant telehealth video conferencing program required to connect with my therapist. In the case of technical challenges, I agree to have a working phone available as back up. In the case that no back up phone is available, I agree to pay for full session fee.

Risks: I understand that risks from telemedicine may include, but are not limited to, despite reasonable efforts on the part of my therapist, that: the transmission could be disrupted or distorted by technical failures; the transmission could be interrupted by unauthorized persons; and/or misunderstandings can more easily occur. I understand that telemedicine-based services may not yield the same results nor be as complete as face-to-face service. Finally, I understand that there are potential risks associated with any form of therapy and that, despite my efforts and the efforts of my therapist, my condition may not improve and may even get worse.

Consent for Treatment: With my signature, I acknowledge that I have read this Telemedicine Informed Consent, had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I understand that have the right to withdraw consent for telemedicine at any time. I hereby consent to engage in telemedicine (e.g., internet or telephone based therapy) as an alternate mode of therapy with Ben Trelease, LMHC, of Ben Trelease, PLLC, according to the terms described here.

______________________	______________________	____________
Client Name	Client Signature	Date

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Client Name	Client Signature	Date

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Ben Trelease, LMHC	Date

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