Pathway to Wellness
Community Clinic

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CLIENT PHONE / TELEHEALTH INFORMED CONSENT

(Required in the Event Telehealth is Necessary)

Definition of Services:

I, (Client Name)_____, hereby consent to engage in telehealth with my treatment provider at Pathway to Wellness Community Clinic, SC. Telehealth is a form of psychotherapy or psychiatric services via internet technology, which can include treatment, consultation, telephone conversations and/or psychoeducation using interactive audio, video or data communications. I also understand that telehealth involves the communication of my mental health information, both orally and/or visually.

Telehealth has the same purpose or intention as psychotherapy or psychiatric services that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced differently than face-to-face treatment sessions.

Client Rights, Risks and Responsibilities:

1. I, the client, have the right to withhold or withdraw this consent at any time without this affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my mental health/medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my treatment is confidential, except when mandated by law or allowed through my permission.

3. I understand that there are risks and consequences of participating in telehealth despite best efforts to ensure the use of high encryption and secure technology. These risks include, but are not limited to, the possibility that telehealth services could be disrupted or distorted by unforeseen technical problems and/or the transmission of my information could be interrupted or accessed by an unauthorized person.

4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth. I am responsible for (1) providing my own necessary equipment for my telehealth sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions. It is the responsibility of my treatment provider to do the same on their end.

I have read, understand and agree to the information provided above regarding telehealth:

_____ _____
Client/Legal Representative signature Date

_____ _____
If signed by other than client, indicate relationship: Date

I understand if I need emergency mental health services, I can contact 988, the Suicide Crisis Lifeline, my local emergency room, or 911:

988 Suicide Crisis and Lifeline: CALL OR TEXT 988 or 988lifeline.org/chat
1-800-273-8255 (TALK) remains available

National Hope Line Network: 1-800-442-HOPE (4673) Text "HOPELINE" to 741741

Sauk County Mental Health Crisis: 608-355-4200

Columbia County Mental Health Crisis: 518-828-9446

Dane County Mental Health Crisis: 608-280-2600