LIFE in BALANCE
COUNSELING & WELLNESS CENTER
Enriching Mind, Body & Spirit

TeleMentalHealth Consent Form

This form is to be completed I addition to **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement. It does not replace **Life in Balance Counseling & Wellness Center** standard Consent and Services Agreement.

I hereby consent to engaging in telehealth with a **Life in Balance** provider as part of my clinical treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/behavioral health information, both orally and visually, to health care practitioners located and licensed in the Commonwealth of Virginia.

I understand that I have the following rights with respect to telehealth:

- I have the right to withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive expectations to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my behavioral or emotional state an issue in a legal proceeding.
- I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmissions of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- In addition, I understand that telehealth-based services and care may not be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g., face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases may even get worse.
- I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.
- I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia Law.

Insurance Reimbursement:

I understand that my insurance may not cover telehealth with my **Life in Balance Provider.** I understand it is my responsibility to contact my insurance company to find out if my policy covers telehealth with my specific **Life in Balance Provider**. I also understand that **Life in Balance** will bill my insurance, but this does not guarantee that my insurance will pay for telehealth mental services with my **Life in Balance Provider**. If my insurance does not pay, I accept full responsibility for any payment due for services rendered by my Provider. If my insurance does not cover telehealth for my **Life in Balance Provider**, I understand that I can request face-to-face services or ask for a referral to a provider that my insurance covers.

Signature of Patient: _____ **Date:** _____