



3830 Packard Rd. Suite 160

Ann Arbor, Mi 48108

Phone: 734-929-9703/Fax: 734-929-9703

---

## INFORMED CONSENT TO TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: \_\_\_\_\_

Clinician: \_\_\_\_\_

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

**Payment for Telehealth Services**

Crossroads Counseling, PLLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, payment is expected at the time of service. We will provide you with a statement of service for your own records if you wish.

**Patient Consent to the Use of Telehealth**

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_