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**Lighthouse Family Center Telethealth Consent for Services**

My signature below signifies my consent to (or consent for a minor child to) engage in telethealth services with a provider at Lighthouse Family Center in accordance with the following expectations and guidelines.

**What is telehealth?**

1. “Telehealth” includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth counseling may include mental health care delivery, diagnosis, consultation, and psychotherapeutic treatment.

2. Telehealth services will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications. Client will need a computer or a phone with a camera and microphone access and internet service in order to participate in telehealth. If one form of technology fails in the course of a telehealth session, an alternate form of communication may be utilized by the counselor (ex. cell phone). Telehealth services provided by Lighthouse Family Center are conducted through utilization of a HIPAA compliant modality; exception to this rule will be waived if/when the governing bodies of the state of Ohio deem it appropriate, and or when information is provided outside of the therapeutic context for purposes of treatment reminders and or scheduling contacts, as well as when client engages in communication with their provider by means of email and or other methods of communication, therefore client is agreeing to waive encryption.

3. Services delivered by the therapist are required by law to take place within the state in which the therapist is licensed, with the exception of crisis consultations or sessions, and telehealth services may not be provided in international jurisdictions. If the client is physically located outside of the state in which the therapist is licensed, client will immediately notify the therapist.

4. Telehealth services are not always a guaranteed benefit covered by all plans and insurers. Lighthouse Family Center is not responsible for verification of coverage of telehealth services. Clients will be responsible for payment of services that are not covered by insurers.

**What are the client’s rights in regards to telehealth?**

1. The client has the right to withhold or withdraw consent to telehealth services at any time. If consent is withheld or withdrawn, the client may have the option to meet with the counseling provider in the office or to request a referral to a local mental health provider.

2. The laws that protect the confidentiality of the client’s personal information in a face-to-face counseling setting also apply to telehealth. As such, the information disclosed by the client during the course of the sessions is generally confidential. The dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without the written consent of the client except in the case of mandatory or permissive exceptions to confidentiality. Such exceptions include, but are not limited to:

• suspected child, elder, and/or dependent adult abuse;

• expressed threat of violence towards an ascertainable victim;

• expressed threat to harm or kill self; and

• court subpoena

3. The client has the right to access his/her personal information and copies of case records in accordance with Federal and Ohio law.

4. The client and provider agree not to record telehealth sessions.

5. The client will be informed as soon as possible of any breach of confidential information.

6. The client and provider agree to be dressed as if they were attending an in-person face-to-face session.

**When is telehealth appropriate?**

1. Client will be informed by their counselor if telehealth is appropriate for their individual needs. Receiving telehealth services may not be advised if the client has experienced any of the following:

• recent suicide attempt(s), psychiatric hospitalization, or psychotic processing (last 3 years)

• moderate to severe major depression or bipolar disorder symptoms

• moderate to severe alcohol or drug abuse

• severe eating disorders

• repeated “acute” crises (e.g., occurring once a month or more frequently)

2. Client agrees that certain situations, including emergencies and mental health crises, are inappropriate for audio/video/computer-based counseling services. These include:

• thoughts of hurting or killing him/herself or another person;

• hallucinations;

• being in a life threatening or emergency of any kind;

• having uncontrollable emotional reactions; and/or

• being under the influence of alcohol or drugs.

3. Client understands that their telehealth provider may not be available for contact between scheduled sessions. If the client is in an emergency or crisis situation (such as those listed above), client should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in their immediate area. If the client is experiencing thoughts of suicide without a clear commitment to safety, client will contact one of the following resources:

• 911

• National Suicide Prevention Lifeline: Call 1-800-273-8255 (or another suicide hotline)

• Crisis Text Line: Text 4HOPE to 741 741

• Local Resources:

Adults- Summit County: Crisis Line: Call 330-434-9144,

Stark County: Crisis Line: Call 330-452-6000,

Children- Akron Children’s Hospital Psychiatric Intake Response Center: Call 330-543-7472

**Are there risks involved?**

1. There are risks and consequences from telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider that:

• the transmission of the client’s personal information could be disrupted or distorted by technical failures;

• the transmission of the client’s personal information could be interrupted by unauthorized persons; and/or

• the electronic storage of the client’s personal information could be accessed by unauthorized persons.

2. Client should use caution when entering private information into a public access computer, or one that is on a shared network.

3. Telehealth may not be as complete as face-to-face services – additional research is needed on the long-term effects of counseling via telehealth versus face-to-face treatment in order to better understand the benefits and limitations of telehealth treatment. If the counselor believes that the client would be better served by another form of intervention (e.g. face-to-face services) the client will be referred to a mental health professional who can provide such services in their area.

4. While the client may benefit from telehealth services, results cannot be guaranteed or assured. There are potential risks and benefits associated with any form of counseling, and despite the client’s efforts and the efforts of the provider, client’s condition may not improve, and in some cases may even get worse.

5. A client’s consent to telehealth services includes the identification of two local (or on-site) contacts that can be reached by the telehealth provider if there is any concern for client’s physical or emotional wellbeing. Such persons may be called upon to contact the client or to alert local authorities in an emergency situation. The individuals that the client identifies for this purpose, with accompanying consent for the telehealth counselors to contact one or both of these individuals if indicated for the client’s safety and wellbeing, are as follows:

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If client chooses to change one or both individuals listed above, or if applicable contact information changes, the client will inform the telehealth provider and request to sign a new informed consent form.

If the client shows signs that indicate he/she may be in danger, client grants Lighthouse Family Center staff permission to contact client by an alternate form of technology (such as phone) and/or to contact client’s emergency contacts listed above to verify the client’s well-being. If client shows signs that he/she may be at serious risk for harm to self or others, client understands that Lighthouse Family Center is required to contact an emergency response personnel to ensure client’s safety.

I have read and understand the information provided above. By signing this document, I agree to follow these guidelines and expectations for telehealth services through Lighthouse Family Center.

**Client name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client/ Parent/ Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_