O'Connell Case, LCSW, LLC
Phone: (812) 518-0380

E-Mail: oconnell@oconnellcase.com

Mailing Address
3513 E. Saddlebrook Court.
Bloomington, IN 47401

Practice Location
2501 E. Third Street
Bloomington, IN47401

Informed Consent for Telehealth Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable mental health professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have these rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions 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; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that my counselor will maintain a confidential physical space to provide my telehealth services and that I am responsible for my own privacy in the space in which I am engaging in telehealth services.
3. I understand that regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to be physically present with me or to render any emergency assistance if I experience a crisis.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. O'Connell Case, LCSW, LLC utilizes secure, encrypted audio/video transmission software to deliver telehealth.
6. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that if my counselor believes that telehealth is not an appropriate medium of psychotherapy for me, she will inform me of this so that we can discuss other options. I understand that

despite my efforts and the efforts of my counselor, my condition may not improve through telehealth, and in some cases may even get worse.
7. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand that my healthcare information may be shared with other individuals for billing purposes.
9. I understand that my express consent is required to forward my personally identifiable information to a third party.
10. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
11. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Telehealth Services

O'Connell Case, LCSW, LLC will bill insurance for telehealth services. You are responsible for ensuring that your insurance plan covers telehealth services. **By requesting that we file with your insurance you are agreeing to pay your full fee and are responsible for any deductible, co-pay, or co-insurance amounts that are not covered by your insurance provider.**

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 with O'Connell Case, LCSW, LLC 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.

Client Printed Name: _____

Signature of Client or Parent/Guardian: _____ Date: _____

Parent/Guardian Printed Name: _____