



Family Guidance Center
Prevention, Treatment and Recovery
"Help For Today, Hope For Tomorrow"
492 Route 57 West, Washington, NJ 07882
Phone (908)689-1000/Fax (908)689-4529
www.fgcwc.org

Telemental Health Informed Consent Form

I _____, (name of consumer) hereby consent to participate in telemental health with _____ (name of provider) as part of my mental health care. I

understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a consumer who are in two different locations.

I understand the following with respect to telemental health:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
- 6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at _____ (consumer's phone number) to discuss since we may have to re-schedule.
- 7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Serving Warren County since 1955
A private non-profit comprehensive behavioral healthcare center.
For a complete list of locations go to www.fgcwc.org

Crisis Hotline: (908) 454-5141



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Technical/Environmental Responsibilities

In the event that telemental health services are being provided to you at a location other than a Family Guidance Center office, you will be responsible for ensuring privacy and security at your location. Recommended actions include:

- Situate yourself in a private location preferably with limited access and minimal chance of being overheard.
- Play music, turn on TV or use noise machine in adjacent rooms to increase your privacy.
- Keeping speaker volume low use of ear buds/headset with microphone attached will prevent your provider from being overheard on your end.
- If you are using WiFi for connectivity make sure your network is secure.
- Make sure all available security features on your device are active and up to date – e.g. firewall on, encryption on, software/security updates installed.
- If you are using a cellular device, make sure your phone is fully charged or you have a charger available because teleconferencing software can be draining on your battery.
- If other people enter your room/area please make the provider aware of them and pause the session until they leave, or you and your provider agree to continue with them present.

Emergency Protocols

My provider needs to know my location during each telemental health session in case of an emergency. I agree to inform them of the address where I am at the beginning of each session. I also give my provider a contact person who they may contact on my behalf in a life-threatening emergency only. This person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

In case of an emergency, my location today is: _____

and my emergency contact person's name, address, phone: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of consumer/parent/legal guardian

Date

Signature of provider

Date

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