| Harrison Ave Campus | Client Name: |
| --- | --- |
| CHILD WITNESS TO VIOLENCE PROJECT | DOB: |

# INFORMED CONSENT TO TELEHEALTH AND VIDEO COUNSELING SESSIONS

I, _____ parent/legal guardian of _____,
understand that due to the COVID-19 pandemic the **CHILD WITNESS TO VIOLENCE PROJECT** is not able to provide in-person/face-to-face counseling services at this time and that my child/children and I can receive services through the use of telehealth or video counseling to engage in or maintain therapeutic work.

Telehealth counseling is a form of mental health service provided via interactive video and audio internet communication technology or telephone which can include consultation, evaluation of safety and basic needs, observation of child play or child-caregiver interaction, developmental guidance, assessment and treatment.

Telehealth phone and video counseling has the same purpose as counseling or psychotherapy sessions that are conducted in person. However, due to the nature of the technology used and to the fact that my child, my child and I, or I will not be in the same room as our therapist to directly engage in therapy interventions and play activities, I understand that Telehealth phone and video counseling may be experienced differently than face-to-face treatment sessions. I also understand that Telehealth video counseling will involve the communication of my child's and my mental health, developmental, medical, educational and other personal information, both verbally and/or visually.

I understand that my child and I have the following rights with respect to Telehealth phone and video counseling:

**Client's Rights, Risks, and Responsibilities:**

1. My child/children and I need to be residents of Massachusetts.

2. I have the option to refuse the delivery of telehealth phone or video counseling services at any time without affecting my child's and/or our in-person services or right to future care or treatment.

3. This consent applies only for the period where the social distancing mandate is enforced. Once the mandate is lifted my child and I may receive in-person services.

4. After 2-3 sessions my child's therapist will discuss with me how communication is flowing via this new mode of working with my child/my child and me.

5. If telehealth video counseling services are not viable or comfortable for my child and/or me, I have the option to receive services via telephone calls.

6. The laws that protect the confidentiality of my child's and my healthcare information also apply to telehealth. As such, I understand that the information disclosed by my child and by me during the course of my child's therapy, observation or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general *Consent Form* and the *Important Information About Professional Confidentiality Form* that I received at the start of my child's treatment.

7. I understand that there are risks and consequences of participating in telehealth video counseling, or other telehealth communication technology (telephone, email) including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my child's therapist, that: the transmission of my child's or my information could be interrupted by unauthorized persons; and/or the electronic storage of my child's or my information could be accessed by unauthorized persons.

8. I understand that there is also a risk that telehealth video services could be disrupted or distorted by technical problems. I understand that my child's therapist or I can discontinue the telehealth session if

it is felt that the video connections are not adequate for the situation and arrange for telephone support as needed.

9. I understand that if my child's therapist believes my child would be better served by another form of therapeutic services (e.g. in-person services, Community Based Acute Treatment) my child will be referred to a professional who can provide such services.

10. I understand that my child and/or I may benefit from telehealth phone and video counseling, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of the therapist, my child's and/or our condition may not improve, and in some cases may even get worse.

11. I accept that telehealth does not provide emergency services. I understand that I will develop a safety plan with my child's/our therapist that includes at least one emergency contact information and the closest Emergency Department to our location. If my child and/or I are experiencing an emergency situation, I understand that I can call 911, proceed to the nearest hospital Emergency Department or call the Mobile Crisis Intervention Services Program (1-877-382-1609) for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or the Crisis Text Line (by texting HOME to 74174) for free 24 hour hotline support. Individuals who are actively at risk of harm to self or others are not suitable for telehealth video counseling services. If this is the case or becomes the case in the future, my therapist will recommend more appropriate services.

12. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in telehealth phone or video counseling services with my child. I am responsible for (1) providing a safe space with the necessary computer, telecommunications equipment (laptop, PC, smart phone, tablet) and internet access (a secure Wi-Fi connection) for telehealth video counseling sessions, (2) encouraging other family members to minimize their streaming or downloading so W-Fi "traffic" at home is minimized during the session, (3) arranging a location with sufficient lighting and privacy that is free from distractions (e.g. the TV, music, telephone calls) or intrusions (from roommates, family members, siblings) for the session. It is the responsibility of our therapist to do the same on their end.

13. I understand that it is important to be on time for the session. If I need to cancel or re-schedule my child's and/or our appointment, I will notify my child's/our therapist via phone or email.

14. I understand that dissemination of any personally identifiable images or information from the telehealth video interaction to other entities or parties shall not occur without my written consent.

**I have read, understand and agree to the information provided above regarding Telehealth phone and video counseling.**

**By signing this permission release, I consent to:**

Telehealth phone or video counseling for ☐ my child, ☐ my child and me

I acknowledge that I have read or had this permission /release form explained to me.

I consent that I fully understand the contents of this consent form, including the risks and benefits of Telehealth phone and video counseling, have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

**<u>For existing clients/patients:</u>**

This agreement is intended as a supplement of the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your verbal/ email consent below indicates agreement with its terms and conditions.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Legal Guardian Name | Parent/ Legal Guardian Signature | Date |
| _____ | _____ | _____ |
| Clinician Name | Clinician Signature | Date |