

**INFORMED CONSENT FOR TECHNOLOGY ASSISTED SERVICES—**

Patient Name:

Date/Time:

Time Zone:

Phone:

Person Completing This Form:

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**Date:**

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**Relationship to client:**

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**Client Name:**

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**Client Date of Birth:**

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**Primary Phone Number:**

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**Alternative Phone Number:**

**Mailing Address:**

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**City, State, Zip:**

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**Email:**

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**Emergency Contacts (Three names & phone numbers)**

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**Code Word:**

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**Informed Consent for Technology Assisted Mental Health Services  
Introduction**

Technology Assisted Mental Health Services, hereafter referred to as TAMHS, involves the use of electronic communications to enable therapists to provide services to individuals who choose access to care via technology assisted services. TAMHS may be used for services such as individuals, couples, or family therapy, follow ups, and training/education in a group setting. TAMHS has over 60 years of development and continues to grow as a mode of delivering care and there are some barriers compared to sitting with a therapist in the same room. Limitations include, but are not limited to, not being an appropriate means of therapy for all populations. The limitations can be addressed and are minor depending on how well the sound and video are working during the TAMHS and depending on the level of care needed by the patient.

**Expected Benefits:** Improved access to care by enabling individuals to access treatment from their home or office.

Expanded access to providers with expertise that may not be available in your local community.

**Possible Risks:** There are potential risks associated with the use of TAMHS. These risks include, but may not be limited to:

Information transmitted may not be sufficient (e.g. Poor resolution of images) to allow for appropriate treatment such as play therapy.

Delays in treatment could occur due to the deficiencies or failures of equipment.

In very rare instances, security protocols could fail, causing a breach of privacy of personal information. However, security measures will be taken to prevent a breach of privacy.

Patient may not choose a private, secure location in which to participate in the TAMHS session.

**Additional Points for Client Understanding:**

1. I understand that TAMHS are completely voluntary and that I can choose not to do or not to answer questions at any time.
2. I understand that none of the TAMHS sessions will be recorded or photographed by the therapist or the patient.
3. I understand that the laws that protect privacy and confidentiality of client information also apply to TAMHS and that no information obtained in the use of TAMHS which identifies me will be disclosed to other entities without my consent.
4. I understand that because this is a TAMHS, there may occasion that it will be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
5. I understand the TAMHS is done over secure communication system that is meets or surpasses HIPPA encryption standards, but there is no absolute guarantee that there a security breach is not possible, and I freely accept the very rare risk that this could affect confidentiality.
6. My therapist explained to me how the TAMHS will be used. I understand the TAMHS sessions will not be exactly as in person session, as I will not be in the same room as my therapist.
7. I understand there are potential risks of technology, including interruptions, unauthorized access, and technical difficulties. I understand my therapist or myself can discontinue the TAMHS sessions if it is felt that use of technology assisted services is no longer effective or appropriate.

8. I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.

9. I understand that I may experience benefits from the use of TAMHS in my care, but that no results can be guaranteed or assured.

10. I understand that if there's an emergency during a TAMHS session, my therapist will call emergency services and my emergency contacts.

11. I understand that if the TAMHS connection drops while I am in a session, that I will have a phone line available and I will contact my therapist.

12. I understand that I will be asked to create a safety plan with my therapist in case of an emergency.

13. I acknowledge that I will not seek to meet with my therapist if I am outside the state of AL.

*I understand the information provided above regarding TAMHS. I have discussed the consent with my therapist or assistant as maybe designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TAMHS in the delivery of care.*

**Signature of patient (or person authorized to sign for a patient)**

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**If authorized signer, relationship to patient:**

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**I have been offered a copy of the consent form (client's initials):**

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**Additional Documentation Required to Begin TAMHS (these must be scanned or photographed and emailed or mailed to the therapist prior to treatment beginning.**

1. Valid Driver's License or State-Issued Identification Card
2. If the patient is a minor and the parents are divorced or child is living with someone other than parents, custody papers evidencing guardians' authority to seek treatment

**TAMHS Safety Plan**

I have provided \_\_\_\_\_ three emergency contact numbers.

If there's an emergency during the session, my therapist has permission to contact my emergency contacts and emergency services.

I have provided \_\_\_\_\_ with a working telephone number to reach me if the TAMHS connection fails during the session.

\_\_\_\_\_ has provided me with a contact number. If connection fails and \_\_\_\_\_ does not call me back within five minutes, then I will call him at this number, \_\_\_\_\_,

Additional items (if needed):

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Signature of a client:(or person authorized to sign for client)

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Date:

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**If authorized signer, relationship to client:**