



Rondeau Therapy Services, PLLC
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0. Telehealth Treatment Consent

Information and Informed Consent for Telemental Health Treatment

Telemental health is live two - way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding

I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telemental health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions. I understand that separate written approval and consent is needed in order for either party to videotape a session.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.

I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand it is my responsibility to provide a private space on my end of the communication to ensure my confidentiality is maintained.

I understand the importance of arriving to appointments on time and prepared and without being under the influence of any mind altering substances.

I understand that while there is empirical evidence base supporting the efficacy of telemental health, it may not yield the same results for me as face to face services will. I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand 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.

I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/ or my emergency contact.

If it is determined telemental health sessions are no longer appropriate, my provider will discuss the need for a referral to a provider or clinic that can better meet my needs.

I understand I will maintain accurate emergency contact information with my therapist. I will also provide my therapist with my location at the start of each visit.

I understand telemental health sessions can only take place if I am within the state of Massachusetts or New Hampshire.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re - contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.

I understand these services may not be reimbursable through my insurance and I am responsible for any fees incurred.