INNOVATIVE INTERVENTIONS, LLC
Methodist Medical Plaza East
9670 E. Washington Street, Suite 200
Indianapolis, IN 46229
(317) 890-5722 Fax (317) 890-5725

Informed Consent for Telehealth Services

Read this consent thoroughly for understanding and to ensure all of your questions are answered before signing to give consent. This consent is to be used in conjunction our Therapist-Patient Services Agreement.

DEFINITION
Teletherapy or Telehealth Services is defined as the use of technology to have a therapy session. We will use a HIPAA compliant platform that uses video and audio technology through a webcam on our devices to connect us securely. The therapist will provide me access to his/her teletherapy platform. The HIPAA compliant platform uses encrypted data streams (AES-256) for our video sessions. No sessions are recorded.

BENEFITS
Benefits of Teletherapy or Telehealth Services include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

RISKS/LIMITATIONS
With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back at the phone number listed in our Therapist-Patient Services Agreement to complete the session.

CLIENT RESPONSIBILITY
I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand that it is my responsibility to have access to an internet connection and have a working camera on my smartphone, computer, or tablet. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations. At the start of each teletherapy session the therapist will need to know your location if you are not in your home. If, for any reason, you are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, then contact emergency services by calling 911.

CONFIDENTIALITY
I understand that there will be no recording or screenshots of any of the teletherapy sessions and that all information disclosed within sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship. I understand that I have a right to confidentiality with teletherapy under the same laws that protect the confidentiality of my personal and health information for in-person therapy. I understand that I waive any confidentiality protections if I am in a public space or have others present near me when I am engaged in teletherapy. I also understand that I waive any confidentiality protections if others have or gain access to my phone, computer or tablet.

CONSENT
By signing this Informed Consent, I voluntarily agree and consent to receive teletherapy services for mental health services (for myself or my minor-aged child) offered through Innovative Interventions, LLC. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Innovative Interventions, LLC at any time. I understand my therapist will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for teletherapy. I acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Patient Name (PRINTED) Date of Birth	Parent/Guardian/ Legal Representative (PRINTED)
Patient Signature Date	Parent/Guardian/ Legal Representative Signature Date
Therapist Name and Credentials (PRINTED)	Therapist Signature and Credentials Date