Northeast DuPage Family & Youth Services
3 Friendship Plaza, Addison, IL 60101
630-693-7934

Telemental Health Informed Consent Disclosure & HIPAA Agreement

I, _____, hereby consent to participate in telemental health with Northeast DuPage Family and Youth Services as part of my psychotherapy. 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 client who are located in two different locations.

NEDFYS Treatment Process:

Counseling/therapy is a voluntary process which involves examining and changing thoughts, feelings, and behaviors. Successful counseling/therapy involves a commitment to this process, often including regular sessions (typically biweekly or weekly). Successful counseling/therapy also requires you, and possibly your support persons or other providers, to be actively involved in sessions and homework between sessions.

Treatment at this agency begins with an assessment. This assessment determines if this agency is able to provide services or treatment appropriate for your needs. Based on your assessment, your therapist may assign a diagnosis, which will be recorded in your file. Based on your assessment and/or response to treatment, your counselor/therapist may recommend further assessments/services at other providers, including a psychiatric evaluation, a psychological evaluation, or medical evaluation. Completing these recommendations is voluntary, but may help your treatment be more effective by providing additional insight. This agency provides multiple styles of counseling/therapy, including but not limited to: individual therapy, couples therapy, family therapy, telehealth, and group therapy. Your therapist will discuss with you which type(s) is/are recommended based on your assessment and response to treatment. It is up to you if you decide to engage in the recommended treatment, but the agency may decline to offer further services if you decline recommended services.

Potential benefits of counseling/therapy include obtaining a professional opinion and changing troubling thoughts, feelings, or behaviors. Risks of counseling/therapy may include confronting difficult emotions, memories, or conversations. Any negative response to treatment should be shared with your counselor/therapist.

Client Rights and Responsibilities:

1. Sessions with a counselor/therapist are confidential, with some exceptions. The following are some exceptions:
   - If you are in counseling/therapy by an order of the court, the results of treatment ordered must be revealed to the court.
   - In the event of a mental health emergency, defined by threat to harm yourself or another individual, your counselor/therapist will complete an assessment of risk, and may recommend further assessment (known as an emergency psychiatric evaluation) at a local emergency room or other location. Your cooperation with these recommendations is requested. If you decline a recommendation, your therapist may act to ensure your safety, including, but not limited to: contacting local authorities to conduct a safety check, contacting your emergency contact, warning the person threatened, involving your parents/guardian, requesting a court-mandated psychiatric evaluation, contacting DCFS, or contacting 911.
   - If physical abuse, sexual abuse, or neglect to any minor child or vulnerable adult is suspected, the counselor/therapist must report his or her knowledge or suspicions to the appropriate authorities.
   - If you are under 18 or have a guardian, the counselor/therapist reserves the right to advise parents or legal guardians about developments that could significantly affect your health or wellbeing.
   - If you are between the ages of 11 and 17, your parent/guardian consents to have your assessment and treatment plan information entered into eCornerstone and updated every 90 days.
   - If you elect to share during a couple's, group, or family session, the agency cannot guarantee that information will not be shared by the other clients within the group.
   - If you elect to communicate with the agency by text or email, the agency cannot guarantee the information will remain confidential, as texting and email are not generally considered secure forms of communication.
   - If the agency receives a court order to provide information in your record or testify, the agency may be mandated to comply.
   - If you bring suit against the agency or a current or former staff at the agency, the agency may utilize information in your record to defend its actions.

2. The counselor/therapist may consult and seek supervision with another professional(s) about your assessment and/or treatment.

3. If you are coming in for legally mandated treatment, the counselor/therapist will ask you to sign a release of information form. The counselor/therapist reserves the right to report the status of your attendance.

4. If you have previously been a client, the counselor/therapist may consult your prior files for more information.

5. You will be asked to complete a set of assessments before, during, and at the end of treatment. These assessments will help structure your treatment plan and monitor progress and effectiveness.

6. The agency is not capable of meeting the needs of all clients for all treatment issues. Following your assessment, your counselor/therapist will discuss the treatment options available, as well as your appropriateness for treatment at this agency. If this agency determines it cannot meet your needs, you will be provided three referrals.

7. You have the right to ask questions and to actively participate in the setting of goals at the beginning and throughout treatment.

8. This agency utilizes interns and unlicensed clinicians to provide treatment services. All unlicensed interns and clinicians are supervised by a fully licensed therapist/counselor.

9. This agency utilizes a cloud-based electronic health record to maintain client files. Clients seeking services at this agency agree to the maintaining of their files in this system

Telemental Health Treatment Disclosures:

1. If you are more than fifteen minutes late to your telemental health appointment, your clinician reserves the right to cancel it.
2. If you are unable to partake in your telehealth session, please provide 24 hours of notice. If you miss or provide less than 24 hours of notice on multiple occasions, your therapist will discuss this with you and may recommend modification of your appointments or termination of treatment.
3. If your clinician believes you are under the influence of alcohol or other illegal substances, the session will be terminated.
4. 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.
5. I understand that there are risks, benefits, 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.
6. 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.
7. 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).
8. 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.

9. 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, your therapist will attempt to call you and potentially re-schedule.
10. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Termination of Counseling/Therapy:

Treatment is voluntary. You may elect to end treatment at any time for any reason. Treatment may end for the following reasons, among others:

- Counseling/therapy may end based on mutual consent.
- Counseling/therapy may end if you have completed the number of contracted sessions.
- Counseling/therapy may end if have met your treatment goals.
- Counseling/therapy may end if you fail to comply with treatment recommendations.
- Counseling/therapy may end if the agency determines your needs cannot be met with the services the agency provides.
- Counseling/therapy may end if you harass, threaten, or harm any property, staff, or another client at the agency.
- Counseling/therapy may end if you do not have a session with your therapist for 30 or more days.

HIPAA Agreement:

You have rights under the Health Insurance Portability and Accountability Act. This act is designed to provide policy standards to protect patients' medical records and other health information. A copy of your HIPAA rights is available to you at https://www.nedfys.org. If you would like a hard copy of NEDFYS' HIPAA Privacy Notice, you may ask your clinician or another NEDFYS staff member at any time and it will be provided to you. If requested by an authorized public health official, NEDFYS is legally obligated to provide protected health information for the purposes of controlling COVID-19.

Your signature below indicates that you have been offered the opportunity to receive and review NEDFYS' HIPAA Privacy Notice and that you agree to its terms.

Telemental Health Emergency Protocols:

NEDFYS needs to know your location in case of an emergency during your telemental health session. By signing, you agree to inform me of your current address prior to or at the beginning of each session. NEDFYS also requires the contact information of a person your therapist may contact on your behalf in case of a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My phone number is: _____

In case of an emergency, my location is: _____

**You will still be required to inform your clinician of your location prior to or at the beginning of each session.

Emergency contact person's name: _____

Emergency contact's phone number:_____

Emergency contact's address: _____

_____

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 client Date

_____

Signature of parent/legal guardian (if client is under 18) Date

_____

Signature of therapist Date