



Consent for Telehealth Services

Telehealth involves the use of electronic communications to enable Art Therapy of MN clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

Telehealth Client Rights

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Art Therapy of MN utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth.

Payment for Telehealth Services

Art Therapy of MN will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard out-of-pocket fees, co-pay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

Patient Consent to the Use of Telehealth

I have read and understood the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Name: _____

Signature: _____ Date: _____