Participant Rights, Guidelines, and Informed Consent for Telehealth

Telehealth allows my counselor to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____ Clinician: _____

Contact Phone/Email: _____

Participant Rights - As a participant in Telehealth services at The Cancer Support Center (CSC), you can expect:

-Access to services as a cancer survivor, a loved one (friend or family member) of an individual with cancer, or a bereaved individual.

-Access to individual, couples, or family therapy.

-Therapy with a licensed professional or with a masters or doctoral-level student who is working under the supervision of a licensed professional.

-Time-limited treatment for issues directly related to cancer. If your therapist deems that issues presented in therapy are not directly related to an experience with cancer, s/he will provide recommendations for services outside of CSC at your own expense.

Confidentiality within the therapeutic relationship

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

Guidelines for participation in Telehealth with CSC:

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to The CSC. My signature below indicates that I have read this Agreement and agree to its terms. If I have any concerns or complaints, I will attempt to address this with my therapist, but can also contact CSC's Clinical Director, Kathleen Daly, LCPC, MAT, at (708)798-9171.

_____

Participant Name **Participant Signature** (Age 12 or older) **Date**

Professional to complete if unable to acquire signature:

I, _____ (name) have been given verbal consent from the above-named patient to sign this form on his/her behalf in order for patient to be contacted by The Cancer Support Center for Telehealth. I have shared the above information with the patient and they verbally agreed to the terms. I will send them a copy of this consent and secure a signature as soon as possible.

Signature: _____ Date: _____