RMH Therapy
(605) 744-1754
www.rmh-therapy.com
info@rmh-therapy.com

Telemental Health Informed Consent

I understand and agree to receive telemental health services through RMH Therapy. This means that Dr. Amy Marschall and I will, through live interactive video or audio connection, meet for scheduled appointments under the conditions outlined in the Therapy Agreement form.

I understand the potential risks of telemental health, which may include:

1. The video connection may not work or may stop working during the appointment
2. The video or audio transmission may not be clear
3. I may be referred to a provider who can offer in-person sessions if it is determined that telemental health is not an appropriate treatment method for me

I recognize the benefits of telemental health, which may include:

1. Reduced cost and time commitment for treatment due to the elimination of travel
2. The ability to receive services near or from my home
3. Access to services not otherwise available in my geographic area
4. Improved privacy due to not being seen in my provider's waiting room

I give consent to engage in telemental health via videoconferencing. I understand that RMH Therapy uses HIPAA-compliant technology via Zoom to transmit and receive video and audio, and RMH Therapy stores all notes and information related to my treatment in a HIPAA-complaint manner through the Therapy Notes platform.

I understand that it is my responsibility to ensure that my physical location during telehealth sessions is private, free of other people, and physically safe. I understand that my provider needs the address of my physical location at the time of my appointment, and I am required to provide this at the start of my appointment. I understand that recording my session is prohibited.

I understand that I have the option to request in-person treatment at any time, and RMH Therapy will provide me with a referral to a provider who offers in-person sessions in my state. I understand that a provider that is physically close enough to offer in-person sessions may not be available.

I understand the limitations to confidentiality in my treatment include if my provider has reasonable belief that I am a danger to myself or others. I understand that, if Dr. Marschall reasonably believes that I plan to harm myself or someone else, she will contact local emergency services to come to my location and ensure my safety.

By signing below, I indicate that I have read and agree to the conditions detailed in this document.

Client Name (print): _____ Date: _____

Legal Guardian (if applicable): _____ Relationship: _____

Client/Guardian Signature: _____