MISSOURI DEPARTMENT OF MENTAL HEALTH
TELEHEALTH INFORMED CONSENT - EASY READ

I, _____ agree to get counseling with _____ through
(Name of Consumer) (Provider Name)
telehealth / videophone (VP) meetings. I understand that my counselor will not be in the same room with me.

I also understand other people may try to watch my counseling session without my permission, but my provider will do their best to keep the counseling session private by using a specially secured network. I also understand that the VP can break down or not work right, and I may not be able to see my counselor that day. If the VP breaks down, my counselor will contact me through my case worker.

I also understand that counseling through VP is not the same as face-to-face counseling. Using the VP means I do not have to travel far to see my counselor if they are in another town and it can be cheaper to meet by VP. I also understand that using the VP for counseling may not work for me. It may be better for me to see a counselor in person, and if so, I will be referred to another counselor. I understand that counseling does not work for everyone. I may not get better from counseling and I may even get worse. I can stop at any time. My information will stay private. I also understand that my sessions will not be videotaped and agree to not videotape my own sessions without my counselor's permission.

I understand that getting counseling through the VP will not cost me any money.

I agree to get counseling through VP. I understand this form will be in my file at _____
(Referring Agency)
and will also be in my file at _____. I have talked with my counselor about all the
(Provider Name)
things in this form and I am satisfied with the information I received.

Signature of Consumer:	_____	**Date:**	_____
Signature of Witness:	_____	**Date:**	_____
Signature of Parent/ Legal Guardian/Representative:	_____	**Date:**	_____