3.1.3.2 TELEHEALTH CONSENT FOR SERVICES

Client's Name: __________________________________ Date of Birth: _____/_____/_____

I understand that my therapist/psychiatrist/case manager (provider) may offer a telehealth session for therapy, case management or medication management using Doxy.me as long as my insurance (or applicable grant funding) allows. My provider has explained to me how the Doxy.me video conferencing technology will be used and that I will not be in the same room as my provider. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation. I understand that if other staff are present during the session other than my provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and I will have the right to request the following:

1) Omit specific details of my psychosocial and medical history that are personally sensitive to me;

(2) Ask the other person to leave the telehealth room: and or (3) terminate the session at any time.

I have had the alternatives to telehealth explained to me, and am choosing to participate in a Doxy.me telehealth. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. I understand that my copay should be the same for telehealth as an in-person session as long as my insurance covers the sessions. If my insurance does not cover the session, I understand that I will be charged the sliding scale. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify:

1) That I have read or had this form read and/or had this form explained to me,
2) That I fully understand its contents including the risks and benefits of the session(s), and
3) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

After being fully informed of the telehealth process, risks and benefits, I voluntarily consent to receive treatment and/or case management services from the Center via telehealth. I further agree that if I bring someone into my counseling or case management session that I am consenting to them having information that is discussed in that session. I understand that this consent does not extend outside of the session unless I have signed an additional specific release allowing them to do so.

X___________________________ ____/____/____
Client's Signature Date

____
Parent, Guardian, or Authorized Representative's Signature
Therapist/Case Manager, obtain proof of guardianship for the client record