Telehealth Informed Consent Form

_____ (patient's name), hereby consents to engage in live, interactive telehealth with _____, who is located at a distant site location for psychotherapy. This distant site location is located at one of the Behavioral Pediatric & Family Therapy Program's offices or my provider's private residence. I understand that "telehealth" includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I agree to use the video-conferencing platform selected for our virtual sessions, and my mental health provider will explain how to use it. I understand that I will need to use a webcam or smartphone during the session and that I will need to be in a quiet, private space that is free from distractions during the session. I will also need to use a secure internet connection, rather than public/free Wi-Fi.

My mental health provider and I will develop a backup plan (e.g., telephone number where I can be reached) to restart the session or reschedule it in the event of technical problems. In addition, we will develop a safety plan that includes at least one emergency contact and the closest emergency room to my location in the event of a crisis situation. If my mental health provider determines telehealth is no longer appropriate or needed, we will resume sessions in person.

I understand that I have the following rights with respect to telehealth:

- I retain the right to refuse telehealth services at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- All existing confidentiality protections shall apply to my telehealth consultation, and nobody will record the session without the permission from the other person(s).
- I understand that there are potential risks unique to telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons.
- I shall have access to all medical information resulting from the telehealth consultation, as provided by law.
- Information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
- If I decline telehealth services, other alternative options are available to me, including in-person services or to seek treatment from alternative providers in the community.

- I will be informed of all people who will be present at all sites during my telehealth service.
- I retain the right to exclude anyone from either the originating or distant site.
- I also understand that my insurance will be billed for this visit, and that I may be billed for what my insurance does not cover. I understand that, if I have any questions about my billing, I will need to talk with the provider's billing office.
- I understand that this consent is valid for six months for follow-up telehealth service with this health care provider.

_____

Patient Name

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____ _____

If other than patient, relationship to patient Reason (minor, incompetent, etc.)

_____ _____

Behavioral Pediatric & Family Therapy Representative Date

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