BROOKINGS
behavioral health & wellness

TELEHEALTH SERVICE AGREEMENT

I (name) _____ agree during the Covid-19 Crisis to receive this health care service as a Telehealth service. I understand that the health care practitioner is located in another location.

Telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for **6 months** for follow-up Telehealth services with the health care provider. I also understand that:

- I can decline the Telehealth service 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.
- If I decline the Telehealth services, during this time of the Covid-19 social distancing, I understand that Brookings Behavioral Health & Wellness **does not** have other options/alternatives available for me, including in-person services at this time.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I understand I am responsible for the security of my personal equipment that I use during my appointment.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service cannot be released to anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from any site during my Telehealth service.
- I also understand that my insurance will be billed for this visit and that I may be billed for what my insurance and/or South Dakota State Funding (if applicable) does not cover as well as copays. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payer.
- I give permission for Brookings Behavioral Health & Wellness to provide limited information to the coordinator at this site for billing purposes. I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months during the Covid-19 crisis and may need to be renewed as deemed necessary.

☐ I accept Telehealth services ☐ I refuse Telehealth services

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent or Legal Representative Relationship Date

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