

**Consent for Telehealth Services**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician/Provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I understand that telehealth is the use of electronic information and communication technologies by a behavioral health care provider (provider) to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving services via telehealth platform.

I understand that there may be potential complications to this technology, including interruptions, and technical difficulties. I understand that the provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.

I understand and confirm that I have been given information on how to navigate telehealth platform and my telehealth sessions. I have had the opportunity to ask questions regarding this procedure such as the equipment, process, etc.

I confirm that benefits, risks and alternatives have been discussed with me in choosing telehealth, including any delays in service, need to travel, or risks associated with not having services provide by Telehealth.

I understand that I must be in a confidential area as agreed upon with my provider. I understand that I am responsible for utilizing a secure space and Victorious Counseling Services will not be responsible for any breach of confidentiality that occurs at my location.

I understand that I will be responsible for any copayments, coinsurances and fees that apply to my telehealth visit. I have been advised as to how to make payments if I am not on location.

I may revoke my consent orally or in writing at any time by contacting provider or program

I understand that the agency has the right to discontinue Telehealth services at any time if no longer deemed appropriate.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of the Patient (or person authorized to sign for the patient) Date**

If authorized signer relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_