SECOND CHANCE
COUNSELING CENTER LLC

**Child & Adolescent/Adult Behavioral Health Clinics Informed Consent for Telehealth Consultations**

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services. Since this is different than the type of consultation with which I am familiar, I understand and agree to the following:

____I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.

____Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording.

____The health care provider will keep a record of the consultation in my clinical record. Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data.

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to clients, including myself, who are residing in the state of Michigan at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to: • It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. • Electronic systems that are

accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network. • Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____ I agree that information exchanged during my telehealth visit will be maintained by the healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the client, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when behavioral health care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

• Telehealth counseling should not be viewed as a substitute for face-to-face counseling. It is an alternative form of counseling with certain limitations.

By signing this document, you agree that telehealth counseling: • may lack visual and/or audio cues that may cause misunderstanding. • may have disruptions in the service and quality of the technology used. • may not be appropriate if you are having a crisis, acute psychosis or suicidal/homicidal thoughts.

**EMERGENCY MANAGEMENT** So that I am able to get you help in the case of an emergency and for your safety, the following is important and necessary. In addition, by signing this agreement form, you are acknowledging that you understand: • You, the client, will inform me, your therapist, of the location in which you will consistently be during telehealth counseling sessions and will inform me if this location changes. • You, the client, will identify on your client information form a person with whom I am authorized to contact in case I believe that you are at risk. If I deem necessary, I will call 911 to evaluate you and/or transport you to a hospital. • All of this information should be updated on your "Initial Evaluation Form" and should remain current.

**EMERGENCY CONTACT** If you are ever experiencing an emergency, including a mental health crisis, please call 911. The Suicide Lifeline is 1-800-273-8255 or go to your nearest emergency room. • If you need to contact me the best method is: By phone: 231-412-0660

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction. For electronic communication between _____ and staff and _____.
(Clinician) (Client)

Client or Legal Representative Signature:_____

Date:_____

Relationship to Client:_____

Client or Legal Representative Name:_____