Henderson Behavioral Health

CLIENT CONSENT FOR A TELEHEALTH SERVICES

Name of Client:_____ **Date of Birth** _____

I am requesting to participate in TELEHEALTH that is under the direction of Henderson Behavioral Health (HBH). The purpose of this telehealth service is to evaluate and treat my medical condition through a two-way interactive audio/video connection between myself and HBH providers. This may include assessments, therapy treatments, and other services as deemed necessary. I understand and approve the following:

1. I may request that any services or the use of telehealth be discontinued at any time. The evaluation, results, and my treatment will be strictly confidential, and I must give my express consent to forward patient-identifiable information to a third party. If I refuse telehealth services, this will not affect my right to future care or treatment, and I risk no loss of or withdrawal from any program benefits to which I would otherwise be entitled. I shall have access to all medical information resulting from the telehealth services as provided by applicable laws.
2. The use of telehealth has been shown to be as effective as traditional care delivery for most outpatient mental health concerns. The provider I see will determine whether the condition being diagnosed and/or treated is appropriate for telehealth and alternative methods of care may be available to me.
3. Potential technology issues can arise during a telehealth session. These include but are not limited to interruption or disconnection of the audio/video link, unclear audio or visual connections, and electronic tampering. If any of these problems occur, the visit might need to be stopped and alternative arrangements made for my follow up care. I have been trained in the use of the equipment, including any family members and support systems and I understand the features of the equipment and how to troubleshoot a problem.
4. The Telehealth Platform uses a high level of security and is HIPAA complaint. The security measures taken include encrypting all data, and password protected access to data and other files. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. I need to work with my provider to address any privacy issues or concerns where I am physically located during telehealth sessions, such as others in the room.
5. As applicable, I will need to supply my own personal computer with adequate processing capabilities to run the telehealth platform, a camera and microphone, and a high bandwidth internet connection. I will need to be in a private location during all sessions and that a test call will be conducted prior to my initial encounter.
6. I am responsible for any co-payments, deductibles, or other charges that are not covered or paid by insurance or other third-party payors – except as prohibited by any state or federal law, or any agreement between my insurance company as a usual course of business. Please refer to Financial Agreement Form.
7. If I have any questions before, during, or after the visit, I may contact the office manager or director at my location of service.

☐ **I certify this form and the telehealth process has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I agree to participate in the telehealth clinic offered by the HBH, and I consent to receive care and consultation via telehealth.**

_____ _____

Signature of Client Date

_____ _____

Signature of Parent of Guardian for clients under age 18 Date

Henderson Behavioral Health

IN-HOME TELELHEALTH GUIDELINES AND AGREEMENT

1. In-home telehealth services are provided as part of a specialty program and will include treatment planning and time-limited treatment with a specific endpoint.
2. Due to the sensitive material that is covered in each session, please be alone in the room (no family or friends), unless otherwise previously agreed upon with your mental health provider. This is to respect the confidentiality of your treatment.
3. You will need to provide an accurate address and/or location at the start of each session.
4. Do not Video/Audio record the session, unless directed to by your provider and you both have given consent.
5. Please do not call your therapist via video teleconferencing while you are driving or in a public area (e.g., public transit, at a restaurant).
6. Please call your provider if you are running late.
7. Please dress as if you were going to an appointment at the clinic.
8. Please have session in a private room with minimal distractions: Cellphones should be turned off or on vibrate, do not text during session, do not e-mail, use the internet, or engage in any other activities on the computer during sessions.
9. Please inform provider of any pets or people in the home at the time of session. Pets must not be distracting to the session. Excluding service dogs or support animals.
10. Please make sure that all televisions, radios, and any electronics (e.g., iPod, stereo) are turned off.
11. Please do not engage in other activities during sessions (e.g., cooking, cleaning, eating). Drinking water is okay.
12. No smoking or use of tobacco or marijuana products during session.
13. Please lockup all weapons (e.g., guns, knives, etc.) and remove them from the room where therapy will be occurring (via teleconferencing).
14. Your provider may determine services may be better offered via in-person care if there are ongoing challenges with technology or treatment goals to ensure you are receiving the best care possible.
15. Please note if there are continuous difficulties with technology (audio/video) a recommendation for services in- person will be made.

EMERGENCY CONTACT INFORMATION AND PROTOCOLS

Address of the location that you plan to access Telehealth services from:

Address: _____

City: _____ Zip: _____

In the event of an emergency, please provide the following information:

- A close personal contact such as a parent, spouse, sibling, or friend with whom you have regular on-going contact:

Name:_____

Relationship: _____ Phone Number:_____

Local Police Department: _____

Phone Number: _____

Technology Assessment - Yes must be answers to all questions.

- If TH is offered, would you be interested in receiving mental health services from our location to your home using videoconferencing technologies?
- Do you have access to a personal computer, tablet or mobile device with speakers and a microphone and a camera?
- At your location/home, do you have broadband wired, or wireless internet connection (3G or 4G/LTE)?

*I have read and understand the above information and agree to participate. HBH reserves the right to terminate telehealth services without cause and without notice should we determine that this service is not appropriate.

_____

Signature