Telehealth Consent

I, ________________________________ (Client/Guardian), hereby give my consent to my provider to provide ________________________________ (Client) with medically necessary live, interactive video telehealth services located at the following distant site location: 297 Knollwood Road, White Plains, NY 10607

I understand that:

a. There are potential benefits and risks of telehealth video services (e.g. limits to patient confidentiality) that differ from in-person services.

b. I retain the right to refuse telehealth video services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

c. All existing confidentiality protections shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth video sessions as appropriate.

d. I shall have access to all medical information resulting from the telehealth communication, as provided by law.

e. Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth video service) cannot be released to researchers or anyone else without my written consent.

f. If I decline telehealth video services for any reason (e.g. technological difficulties, etc.), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.

g. I will be informed if this telehealth video service will be recorded.

h. I will be informed if any additional people beyond my provider will be present at all sites during my telehealth video service.

i. I retain the right to exclude anyone from either the originating or distant site.

j. A safety plan is needed that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
k. My provider may determine that due to certain circumstances, telehealth video services are no longer appropriate and that we should resume our services in-person or through other alternative options.
l. This consent is valid for six months for follow-up telehealth video services with this health care provider.
I have read this document carefully and my questions have been answered to my satisfaction.

DOB: ________________

Print Client Name

____

Relationship to Client Phone Number

____

Email Address (where Date Signed: ______________

Client/Guardian Signature *

____

Emergency Contact link to sessions can be sent) Phone Number (if problems occur)
*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents. Additionally, if you choose to sign this document electronically, you agree your electronic signature is the legal equivalent of your manual signature on this document.

INFORMED CONSENT (Cont.)

My therapist may call me at my home. My home phone number is:_______________________________________
Message Ok?_________

My therapist may call me on my cell phone. My cell phone number is:____
Message Ok?__________

My therapist may call me at work. My work phone number is:____
Message Ok?___________

My therapist may send mail to me at my home address:
____

My therapist may send mail to me at my work address:
____

My therapist may communicate with me by email. My email address is:
____

(I understand that email is not a completely private form of communication).
My therapist may send a fax to me. My fax number is:
____

In case of emergency, I prefer my therapist contact me at this number:_____________________________________

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Your signature indicates that you have read all proceeding pages of this agreement for services carefully and

understand its contents. Your signature also states that you have read the above privacy practices and that you have been offered a copy for your records.

Please ask your therapist to address any questions or concerns that you have about this information before you sign! Please note: typing your full name (first, middle, and last) and the date constitute a legal signature for the purposes of this form. You always have the option of printing this form and bringing it to your first appointment.

Signature of Patient(s)

____

Date____________

Signature of Patient(s) and Authorized Representative(s)

____

Date___________