**INFORMED CONSENT FOR TELEMEDICINE SERVICES**

**Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I understand the following with respect to telemental health:**

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider, psychiatrist, assessor, therapist and/or paraprofessional to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Advance Therapeutic Concepts via telehealth to provide health care **AND** behavioral health care services to me via telehealth.

I give my consent to be interviewed by the consulting health care provider, psychiatrist, assessor, therapist and/or paraprofessional. I also understand other Individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, your insurance carrier will have access to your medical records for quality review/audit.

I hereby release Advance Therapeutic Concepts, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs. I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth visit under the conditions described in this document.

I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic

symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be

determined that telehealth services are not appropriate, and a higher level of care is required.

I understand that during a telehealth session, we could encounter technical difficulties

resulting in service interruptions. If this occurs, end and restart the session. If we are unable to

reconnect within ten minutes, the therapist/paraprofessional will call to discuss since we may

have to re-schedule.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting **Advance Therapeutic Concepts at (678)344-7836**.

I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. **Emergency Protocols** I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and my emergency contact person’s name, address, phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have read the information provided above and discussed it with my therapist. I understand**

**the information contained in this form and all of my questions have been answered to my**

**satisfaction.** **As long as this consent is in force (has not been revoked) Advance Therapeutic Concepts may provide health care services to me via telehealth without the need for me to sign another consent form.**

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**Client Name Client Signature Date/time**

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**Legal Guardian Signature(if client under 18) Relationship Date/time**

**I have been offered a copy of this consent form (patient’s initials)\_\_\_\_\_\_\_\_\_\_**