TELEHEALTH SERVICES INFORMED CONSENT

Telehealth is the practice of delivering clinical care through electronic communication and telecommunication technologies. Telehealth service delivery allows a member who is in a separate location from a provider to receive care. It provides additional flexibility with scheduling and more readily access to mental health treatment to those who reside in rural areas. Telehealth requires individuals to have continual access to technology capable of this service delivery and access to broadband internet may be necessary for telehealth to be a suitable option for care. Telehealth is not a requirement for service delivery.

I, _____, hereby request and consent to participate in telehealth services with the Southwest District Health clinician as a part of my therapeutic services.

To begin each session, I will be asked to confirm my physical location. I may also be asked to present my state-issued identification, so the provider may verify my identity. I agree to prepare for my appointment by positioning myself in a suitable location that will allow for sufficient privacy, so others will not overhear. I agree not to share my visit link with others.

While there are benefits to telehealth, there are also risks which may include a disruption of transmission by technology failures, interruption or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. No assurances or guarantees can be made concerning the results or outcomes of any services provided. Alternatives to telehealth include in-person counseling offered at the Caldwell office.

Confidentiality

Privacy Rules and Security Rules under the Health Information Portability and Accountability Act (HIPAA) apply within the context of the client-counselor relationship through all formats of delivery. Confidentiality requirements are applicable both in-person and in telehealth, with the same exceptions.

The clinician is mandated to break confidentiality in the following circumstances:

- If I indicate I am going to harm myself or someone else
- If abuse, neglect or abandonment of a minor is disclosed or suspected
- If abuse, neglect, or exploitation of a vulnerable adult is disclosed or suspected
- If a court ordered subpoena is received

I understand and agree that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

If I encounter technical difficulties, which result in service interruption, I am directed to end and restart the session. If I am still unable to reconnect within ten minutes, please call the provider at (208) 455-5300 to discuss since we may have to re-schedule.

I have the right to withdraw consent for telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand if I am experiencing 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.

Emergency Protocols

Clinicians are required to obtain emergency contact information from members engaging in telehealth services. In the event of an emergency, the clinician may need to contact an emergency contact and/or the appropriate authorities to facilitate the level of assistance needed. This individual will only be contacted in the event of an emergency and only a minimum amount of information necessary will be disclosed (restricted to the emergency).

I designate the following individual as my emergency contact:

Name: _____

Telephone: _____

Address: _____

I have been made aware of the benefits and limitations, and expectations with telehealth services and have had the opportunity to discuss any questions or concerns with my provider.

By signing this you acknowledge the information discussed above and consent to telehealth treatment being provided by the SWDH Behavioral Health Team.

Signature of Client: _____ Date: _____

If applicable. Under penalty of perjury, you are authorized to initiate services on behalf of the minor identified.

Parent/Legal Guardian Name: _____ Relationship: _____

Parent/Legal Guardian Signature:_____ Date:_____

Clinician Signature: _____ Date:_____