

Laura M. Lentz, P.C.

Informed Consent for Treatment for Telehealth

Telehealth or tele-mental health is when mental health services are provided virtually through a safe, secure, HIPAA compliant video chat platform, in place of an in-office visit.

Nebraska's statutes pertaining to Nebraska's Telehealth Act are cited at 71-8501.

*** Please initial that you have read and understand the following:

_____ Telehealth is the delivery of services using interactive technologies between a practitioner and a client who are not in the same physical location.

_____ All clients using telehealth services must be physically in the state of Nebraska where the therapist is licensed.

_____ The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

_____ Telehealth is provided by technology which can provide benefits and limitations to the mental health industry.

_____ The client will need access to access a computer or device to access telehealth and will need to be familiar with the appropriate technology in order to participate in the service provided.

_____ The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

_____ During telehealth sessions details of my health information and personal information may be discussed with myself and my therapist through the use of interactive video, audio and any other telecommunications necessary.

_____ I (the client) may decline any telehealth services at anytime without jeopardizing my access to future care, services and benefits.

_____ These services rely on technology which allows for great convenience. There are risks in transmitting over technology that include, but are not limited to, breaches of confidentiality, theft or personal information, and disruption of service due to technical difficulties.

_____ My practitioner and I (the client) will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today and modify our plan as needed.

_____ In emergencies, in the event of disruption of services for routine or administrative reasons, it may be necessary to communicate by other means.

_____ It is my (the client's) responsibility to maintain privacy on the client's end of the communication.

_____ Insurance companies, those authorized by the client and those permitted by law may also have access to records or communications.

_____ The laws and professional standards that apply to in-person mental health services also apply to telehealth services. This document does not replace other agreements, contracts or documentation of informed consent.

_____ It is the responsibility of the client to check with their insurance provider that services provided through the telehealth platform are covered under their benefits.

"I acknowledge that if I am facing an emergency situation that could result in the harm to me or to another person, I am not to seek a Telehealth session. Instead, I agree to seek care immediately through the nearest hospital emergency department or by contacting 911, the Suicide Prevention Lifeline at 1-800-273-8285, or the Crisis Text Line by texting 741741. Prior to beginning Telehealth services, an emergency plan will be created in the event of an emergency. I agree to provide my practitioner with the following information before each Telehealth session: the physical address of where I am located, who I am with, and who my provider should contact in the case of an emergency during our Telehealth session. I, therefore, consent for my practitioner to contact this individual only in the case of an emergency."

I, _____, give consent to Laura M. Lentz, LIMHP, for treatment for therapy/counseling for () myself or for () minor _____.

I provide my consent to Laura M. Lentz, LIMHP, to perform the procedures and treatment necessary for my condition that are generally used in this and similar settings.

Client Signature: _____

Date: _____

Guardian Signature: _____

Date: _____