INFORMED CONSENT FOR TELEMENTAL HEALTH SERVICES

I understand that telemental health services is the use of electronic information and communication technologies used by a behavioral health care provider to deliver services to a client when s/he is located at a different location or site than the provider.

I understand that the telemental health visit will be done through a two-way video link-up. The behavioral healthcare provider will be able to see me on a screen and hear my voice. I understand that I will be able to see and hear the behavioral healthcare provider on my device.

I understand that the laws protecting privacy and the confidentiality of behavioral health information (HIPAA, 42CFR Part II) also apply to telemental health services.

I understand that I am responsible for any copayments or coinsurance that apply to telemental health services.

I understand that I have the right to withhold or withdraw this consent for the use of telemental health services at any time without effecting my rights to future care or treatment.

By signing this form, I understand that I am consenting to receive behavioral health care services using telemental health.

_____ _____

Client Date

_____

Printed Name

Client given copy of consent _____ Client refused copy of consent ____