

Assessment Date: ____/____/____



CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

Client's Name: _____

Client ID: _____

DOB: ____/____/____

Telehealth is the delivery of health care services using interactive audio and visual (video) electronic systems, or telephone, where the health care provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Telehealth provides convenience and increased accessibility to health care for individuals to access care from a variety of locations. However, there are potential risks to telehealth, including but not limited to, interruptions, unauthorized access, and technical difficulties.

Potential risks and limitations may also occur when the signal or information transmitted is not sufficient to allow for appropriate decision making by the health care provider. While security protocols protect patient privacy, no system is completely immune from the risk of data breach of protected health information. The possibility exists that secure signals may be accessed via hacking at the points of transmission or reception of the telehealth session.

Best Practices:

If you will be joining a telehealth session from your home or a location of your choosing, it is advised that you do not use public internet or public Wi-Fi networks. Please also be aware of your surroundings and choose a suitable location where you are unlikely to be interrupted or overheard. I understand that I am responsible to ensure privacy of my location and for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

Consent:

I hereby voluntarily authorize Jefferson Center for Mental Health, its representatives and staff (collectively, "Jefferson Center") to provide telehealth (streaming video along with audio or telephone) during the course of my treatment solely for the purposes of treatment.

I understand that in the midst of a public health crisis, such as the Coronavirus (Covid-19) pandemic, Jefferson Center is unable to provide face to face services. Accordingly, if I choose not to use the telehealth mode of treatment during a public health crisis, I will be unable to access ongoing services during this time. However, the option for face to face services may be available in the future.

During my telehealth visit, I further understand that the responsibility of Jefferson Center concludes upon the termination of the telehealth connection and Jefferson Center is not responsible for the actions of the distant site.

Acknowledgements:

I understand that my withdrawal of consent will in no way affect my future care or treatment.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; where I am in such mental or emotional condition to be a danger to myself or others; and where I make my mental and emotional state an issue in a legal proceeding.

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Acknowledgements Continued:

I understand that the health care provider has the right to withhold or withdraw his or her consent for use of telehealth during the course of my care at any time.

I understand that all rules and regulations that apply to the practice of medicine and related health care in the state of Colorado also apply to telehealth. This includes my right to access clinical information resulting from telehealth services, as allowed by the law.

I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured.

I agree I will not make a video or audio recording of my telehealth session.

Just In Case:

If technical difficulties interrupt your telehealth session, the behavioral health provider will call you to troubleshoot the issue or continue the session by phone. If you do not receive a call, you may phone the provider.

If at any point you experience discomfort or concern about your current status, please notify the behavioral health provider. If you think you have a medical or psychiatric emergency, and are not currently in session with your provider, please call 303-425-0300 to request emergency services or visit the Crisis and Recovery Center located at 4643 Wadsworth Blvd., Wheat Ridge, CO 80033.

Term of Authorization:

My signature below indicates that I have read this Consent document carefully, I understand the risks and benefits of the telehealth appointment, I have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein. I expressly agree that this Consent is intended to be as broad and inclusive as permitted by the laws of the state of Colorado, and if any portion hereof is held invalid, it is agreed that the remainder will continue in full force and full effect.

Signature of Patient or Parent/Guardian/Authorized Representative

Printed Name and Relationship to Patient

Signature Date: ____/____/____

No Signature - Signature on Paper: _____ **Verbal Consent Given:** _____