# Consent for Telehealth Services

## Renew Counseling Associates

Addendum

Electronic Transmission of Information: I, the undersigned, agree to participate in technology-based consultation and other healthcare-related information exchanges with Renew Counseling Associates, a behavioral health care center (“center”) and its practitioners ("practitioners"). This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application: It may also mean that my private health information may be transmitted from my practitioner’s mobile device to my own or from my device to that of my practitioner via an ‘application” (abbreviated as “app”). I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment: I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer’s computer or network. I am aware that any information I enter into an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification: I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Telehealth Process: My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services: Iunderstand that it is my duty to inform my practitioner of electronic interactions regarding mycare that I may have with other health care providers.

Electronic Presence: In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an “app” will be transmitted electronically to and from myself and my practitioner.

Limitations: Regardless of the sophistication of today’s technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks: I understand that telebehavioral health is a new delivery method for professional services, in an

area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons. In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the practitioner.

Release of Information: I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinicalor medical record information.

Discontinuing Care: I understand that at any time, the counseling sessions(s) can be discontinued either by me or by my designee or by my health care practitioners. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the session(s) or use of technology will not affect my continued treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality: I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others. Alternatives: The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telehealth counseling sessions(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth session's effectiveness.

Records: I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request. I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy. Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs. I hereby authorize these disclosures to take place without prior written consent.

Compensation: I understand that I am not entitled to royalties or to other forms of compensation for participation in any telehealth counseling session(s) or other information exchange.

Contact Information: I have received a copy of my practitioner’s contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care: I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telehealth counseling session(s). Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

Release of Liability:I unconditionally release and discharge Renew Counseling Associates, its affiliates, agents, employees and my practitioner and his or her designees from any liability in connection with my participation in the remote telehealth counseling session(s).

Final Agreement:I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and havereceived satisfactory answers.With this knowledge, I voluntarily consent to participate in the telehealth counseling session(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

**Name**

First Name Last Name

**Date**

Month Day Year

**Signature**