

SENDAN CENTER Telehealth/Telemedicine Informed Consent Form

I _____, consent to engaging in telehealth/telemedicine with the Sendan Center as a part of the evaluation and treatment process, including but not limited to psychotherapy, ABA / behavioral and medical services. I understand that telehealth/telemedicine may include, but is not limited to, mental health evaluation, assessment, consultation, treatment planning, parent training and psychotherapy. Telehealth/telemedicine will occur primarily through interactive video conferencing through a HIPAA-compliant video conferencing service, assuming such service is available.

I understand I have the following rights with respect to telehealth/telemedicine:

- 1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
- 2) The laws that protect the confidentiality of my personal information also apply to telehealth/telemedicine. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including, but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth/telemedicine interaction to other entities shall not occur without my written consent.
- 3) I understand that there are risks and consequences from telehealth/telemedicine including, but not limited to, the possibility, despite reasonable efforts on the part of the Sendan Center that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as in-person services. I understand that, if my therapist believes I would be better served by other interventions, I will be referred to a mental health professional who can provide those services in my area/region. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist/medical professional, my condition may not improve or may deteriorate.

- 4) I understand that I may benefit from telehealth/telemedicine services, but that results cannot be guaranteed or assured. I understand that the use of audio/video systems are not

100% secure and may have issues with connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth/telemedicine services. I will not hold the Sendan Center or its staff liable for gathering or use of client information by these service providers.

5) I understand I have the right to access my personal information and copies of chart documents. I have read and understand the information provided here. I have discussed these points with my involved Sendan Center professional, and all of my questions regarding the above matters have been answered to my approval; I have kept a copy of this form for my records, and know that I may ask further questions at any time.

6) By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy or medical services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility or call National Suicide Lifeline at 1-800-273-8255. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, experiencing psychotic symptoms, if I am in a life threatening situation, and/or if I am abusing drugs or alcohol and I am not safe.

If the client is a minor child, "I" refers to the parent / guardian's consent on behalf of the child.

Printed Name of Child: _____

Signature of client/parent/guardian	Date	Time
-------------------------------------	------	------

Printed name of signing client/parent/guardian	Relationship (If applicable)
--	------------------------------