# INFORMED CONSENT FOR TELEHEALTH SERVICES

| Client Name: | Date of Birth: | Avatar ID: |
|---|---|---|
| Client Location/Address: | | |
| Provider Name: | Service Location: | |
| Provider Credential: ☐MD, ☐NP, ☐LCSW, ☐LMFT, ☐AMW/AMFT, ☐MHRS, ☐SUD Certified/Registered, ☐Other: (list) _____ | | |
| Provider Type: ☐Prescriber, ☐FQHC Therapist, ☐LPHA, ☐MH Coordinator, ☐SUD Counselor, ☐OT, ☐Other: (describe)_____ | | |

**PURPOSE:** In order to improve timely access to treatment and support ongoing treatment services, the County of Santa Cruz makes some behavioral health services available by two-way interactive video communications. This two-way interactive video communication is referred to as “telehealth” service. Telehealth services may include evaluations, including diagnosis, by a psychiatrist or nurse practitioner, or by other Behavioral Health clinical staff, and ongoing treatment counseling services. **The purpose of this form is to obtain your consent for establishing telehealth services with one of our network Behavioral Health providers.**

**NATURE OF TELEHEALTH SERVICE:** Telehealth involves the use of audio, video or other electronic communications to interact with you, consult with your Behavioral Health provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telehealth session with a Behavioral Health provider, you and the provider will be communicating through a computer or application that has a camera and microphone so you can see and hear each other. If you participate in a telehealth appointment with you and one of your multi-disciplinary treatment providers, such as a CFT session, details of your medical history and personal health information may be discussed in these sessions with other health professionals through the use of interactive video, audio and telecommunications technology. All licensed providers are licensed by the State of California.

**RISKS, BENEFITS AND ALTERNATIVES:** The benefits of telehealth services include having access to Behavioral Health specialists and additional medical information and education without having to travel outside of your home or local health care community. A potential risk of telehealth services is that because of your specific behavioral health condition, or due to technical problems, a face-to-face consultation still may be necessary after the telehealth appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy; and you and your provider may need to access your identified crisis de-escalation plan during or between sessions.

Since telehealth service is different from an in-person visit**, we want you to understand and agree to the following:**

1. For remote home-based telehealth services, the provider will be at a different location from me. I will operate my own computer/application to access the telehealth appointment and I may call my provider as needed to explore possible technical support and/or request reschedule of appointment.
2. For County clinic-based telehealth service appointments, a staff person will be available to assist me if needed. I will be told how to access that staff person prior to the beginning of the telehealth session.
3. I will be informed if any additional individuals are to be present other than myself, individuals that I have asked to be in the session with me, or someone from my treatment team. I will be asked to give my verbal permission prior to additional individuals being present.
4. No video or audio recordings will be made of the telehealth service.
5. I understand my provider and I may establish and access a crisis de-escalation response plan in case it's needed during, after or between telehealth sessions. Also, I am aware I can always call the County Behavioral Health at toll-free number: 800-952-2335 for assistance or 911 for emergency services.
6. The Behavioral Health provider who conducted the telehealth examination and/or treatment service with me will write a record summarizing the service in my electronic medical record.
7. All existing confidentiality protections under federal and California law apply to information used or disclosed during my telehealth service.
8. I understand that if I participate in a telehealth session with multiple people, such as a treatment group and/or multidisciplinary care meetings, my personal email address may be seen by other group members, and I may see theirs. I agree to the group's rule to not misuse any email address. I am aware that I can opt-out of group telehealth sessions at any time by declining a group meeting invitation or by not joining the group meeting.
9. I understand that if I choose to have **in-person services**, non-medical transportation benefits for Medi-Cal beneficiaries are available.
10. I have read and understand the above stated risks and benefits of having a telehealth visit with the provider and have been offered the opportunity to ask further questions. I am aware that I can decide to cancel and not continue with this scheduled telehealth appointment.

Noting all the above, I understand that my participation in the process described (called "telehealth") is voluntary.

**I further understand that I have the right to:**

1. Request and receive services in-person.
2. I may withhold or withdraw my consent to a telehealth service at any time before and/or during the session without it affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
3. I may refuse the telehealth service or stop participation in the telehealth session at any time.
4. I may request that anyone else present in the session leave the room at my request.
5. I understand that stopping participation in the telehealth session may require that I be scheduled for another appointment with the provider in order to complete the session, which will be provided based on the providers availability and the urgency of the request.
6. I understand that my participation in treatment appointments with my provider is an important role for my ongoing wellness and recovery success.

I acknowledge that the Behavioral Health providers involved have explained this process in a satisfactory manner and that all questions that I have asked about telehealth services have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
*(if applicable)*

Relation to Client: _____

Interpreter Name: _____ Date: _____
*(if applicable)*

Witness: _____ Date: _____
*(required if client unable to sign)*

**DECLINE:** I acknowledge I have been offered services through telehealth session(s) and decline to participate in a telehealth session as described above.

Client Signature: _____ Date: _____