Telehealth Consent

I, _____ (Client/Guardian), hereby give my consent to my provider to provide

_____ (Client) with medically necessary live, interactive video telehealth services located

at the following distant site location: 2001 Pine Lake RD, STE 200, Lincoln, NE 68512.

I understand that:

a. There are potential benefits and risks of telehealth video services (e.g., limits to patient confidentiality) that differ from in-person services.
b. I retain the right to refuse telehealth video services at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
c. All existing confidentiality protections shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth video sessions as appropriate.
d. I shall have access to all medical information resulting from telehealth communication, as provided by law.
e. Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth video service) cannot be released to researchers or anyone else without my written consent.
f. If I decline telehealth video services for any reason (e.g., technological difficulties, etc.), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
g. I will be informed if this telehealth video service will be recorded.
h. I will be informed if any additional people beyond my provider will be present at all sites during my telehealth video service.
i. I retain the right to exclude anyone from either the originating or distant site.
j. A safety plan is needed that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
k. My provider may determine that due to certain circumstances, telehealth video services are no longer appropriate and that we should resume our services in-person or through other alternative options.
l. This consent is valid for six months for follow-up telehealth video services with this health care provider.

I have read this document carefully and my questions have been answered to my satisfaction.

_____ DOB:_____
Print Client Name

_____ Date:_____
Client/Guardian Signature *

_____
Emergency Contact Person Phone Number

_____
Email Address (where link to sessions can be sent) Phone Number (if problems arise)

KLR Counseling, LLC
Kipp Ransom, LIMHP, LPC
2001 Pine Lake RD STE 200 Lincoln NE 68512
Pho: (402) 261-8313 Fax: (866) 321-6448