Informed Consent for Telehealth Services

I, _____ (Client/Guardian), hereby give my consent to **Shaylee Schroeder, PSY D, LLC** to provide _____ (Client) with live, interactive video telehealth services located at the following distant site location: **2001 Pine Lake Road, STE 200, Lincoln, NE 68512.**

I understand that:

- There are potential benefits and risks of telehealth video services (e.g., limits to client confidentiality) that differ from in-person services.
- I retain the right to refuse telehealth video services at any time without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- 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.
- I shall have access to all medical information resulting from the telehealth communication, as provided by law.
- Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
- If I decline telehealth video services for any reason (e.g., technical difficulties), I will collaborate with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
- I will be informed if additional people beyond my provider will be present during my telehealth session.
- I will be informed if the telehealth sessions will be recorded.
- I retain the right to exclude anyone from either the originating or distant site.
- I am required to provide an emergency contact and will collaborate with my provider to identify the closest emergency room to my location, in the event of a crisis situation.
- 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.
- This consent is valid for six months for follow-up telehealth video services with this health care provider.

I have read **this document** and the **Patient Rights and Responsibilities for Participation in Telehealth Services** document carefully and my questions have been answered to my satisfaction.

_____ _____

Client Name (Print) **DOB**

_____ _____

Client/Guardian Signature **Date**

_____

Emergency Contact **Relationship to Client** **Phone Number**

_____

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