easterseals
Capital Region &
Eastern Connecticut

TELEHEALTH CONSENT

I,_____, the client/patient, understand and agree to the following with respect to telehealth services that I may participate in:

As a client or patient receiving telehealth services through telebehavioral health technologies, I understand that telehealth is the delivery of health services using interactive technologies (use of audio, video, or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

In order to connect to your provider virtually, your provider will send you an e-mail with a link to join their online personal meeting set-up through Zoom, or other like application.

Telehealth services rely on technology, which allows for greater convenience in service delivery. I understand that there potential risks and benefits with telehealth that differ from in-person appointments. I understand that I should confirm with my insurance company that the telehealth sessions will be reimbursed; if they are not reimbursed, I am responsible for full payment.

There are potential risks of transmitting information over technology that include, but are not limited to, breach of confidentiality, theft of personal information, and disruption of services due to technical difficulties. I understand that the platform being used is not encrypted and knowingly accept this.

There will be no recording of any online session by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written permission, expect where disclosure is permitted and/or required by law.

The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth services unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; you raise mental/emotional health as an issue in a legal proceeding).

I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.

I understand that I need to access to WiFi and a device that has a webcam and audio (such as a smart phone, tablet, laptop, etc.). It is important to use a secure internet connection rather than public/free Wi-Fi.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device that I am using and in my own physical location. I am also solely responsible for any cost for any necessary equipment, accessories, software, data charges, etc. to take part in telehealth services. I understand that I am responsible for using this technology in a secure and private location that is free of distractions. My provider will take every precaution to insure a secure and private telehealth session on their end.

It is important to be on time. If I need to cancel or change my telehealth appointment, you must contact us at 860-270-0600 x 100 as much in advance as possible.

I understand that in the event of technical problems where we may need to restart the session or reschedule it, my provider will attempt to reach me at the phone number and/or e-mail address I provided. If the session is interrupted, disconnect from the session and my provider will attempt to reconnect via the telehealth platform on which we were using.

I have read the information provided above. I understand that I have the right to withdraw my consent at any time without affecting my right to future services or program benefits to which I would otherwise be entitled. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Patient/Client Signature Date

_____

Patient/Client PRINT Name

_____ _____

Parent, Guardian, or Legal Representative Signature (if needed) Date

_____

Parent, Guardian, or Legal Representative Signature PRINT Name