NORTHLAND COUNSELING SERVICES

INFORMED CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

I, _____, have been asked to receive behavioral health services via TeleHealth. I understand that I will be receiving health care services through interactive videoconferencing equipment. My Therapist or another staff member of Northland Counseling Services has explained to me how the videoconferencing technology will be used to provide such services to me. I understand that my TeleHealth sessions will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand that my participation in TeleHealth is voluntary, and that I have the right to refuse to take part, limit, or to stop taking part in TeleHealth interactions at any time without affecting my care, now or in the future, at Northland Counseling Services. I further understand that I do not have to take part in TeleHealth to be treated at Northland Counseling Services, however during the Coronavirus (COVID-19) Pandemic in order to protect our clients, staff and community outpatient services will be primarily provided through video conferencing telehealth.

The benefits of Telehealth have been explained to me, including:

Reduced travel for healthcare.

Increased convenience.

Focused healthcare information.

Improved access to healthcare services and providers.

I have also been advised that there are potential risks to this technology. These risks may include:

The audio/video connection may fail to work or may be interrupted or become disconnected during the consultation.

The interactive connection may not provide a picture that is clear enough to meet the needs of the consultation.

There is a small chance that someone could access the consultation through the interactive connection by electronic tampering.

I understand the health care provider at the telehealth site will have access to any relevant health information about me including any psychiatric and/or psychological information, alcohol and/or drug abuse information, and mental health records.

I understand that my personal information will be held in strict confidence, and shared only on a need-to-know basis, and even then only the minimum information necessary will be disclosed.

I understand that there will be confidential records of my TeleHealth sessions(s) maintained by Northland Counseling Services, and that I have the right to inspect all information transmitted during a TeleHealth session or consultation, and may receive copies of this information for a reasonable fee.

I understand that there will be ongoing TeleHealth sessions, but if at any time during my TeleHealth sessions I do not wish to participate, I have the right to refuse to take part in TeleHealth interactions.

I understand that I must give my informed consent to participate in TeleHealth and receive TeleHealth services.

I understand that, if my therapist believes that I am a danger to myself or others, or unable to care for myself, they will take the appropriate measures to ensure my safety as taken in a face to face session.

I understand that, if I threaten to harm any identifiable person, a clinician is required to warn that person and inform law enforcement.

I understand that, if a clinician suspects abuse or serious neglect of a child, helpless adult, or senior citizen, a report must be made to the designated agency within 24 hours and permission is not required.

I certify that this form and the purposes and processes of TeleHealth services have been fully explained to me and I have read and understand this form or have had it read to me. I understand the risks and benefits of Telehealth technology and services. I agree to participate in the TeleHealth services offered by Northland Counseling Services and I consent to receive mental health care and consultation via TeleHealth.

This informed consent will remain in force and effect for a period of **twelve (12) months** from the date below, unless I provide a written notice of the withdrawal of this consent.

Signature of Client:_____ **Date**:_____

The above informed consent is given on behalf of _____because the client is a minor or has been determined to be incompetent to give consent.

Signature of Parent or Legal Guardian:_____ **Date**:_____

Relationship to Client_____