BEHAVIORAL HEALTH SERVICES TELEHEALTH INFORMED CONSENT
(Client at CAHSD Location)

1. I understand that my healthcare provider, Capital Area Human Services District (CAHSD), wishes me to engage in a telehealth consultation. A telehealth visit includes a telephonic or video consultation by a CAHSD healthcare provider. I will have the same out-of-pocket costs as a face-to-face visit.

2. My healthcare provider has explained to me how the video conferencing technology or telephonic visit will be used for my visit and will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my health care provider. The standard for medical care will be met even though my health care provider and I are not in the same room.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing or phone connections are not adequate for the situation. A healthcare provider will then assume my care at my physical location. None of the telehealth session will be recorded; however, my clinical record will be maintained in the CAHSD electronic medical record. CAHSD will follow all Privacy Notice Policies.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the termination of the consultation at any time.

5. I have had the alternatives to a telehealth consultation explained to me, and I choose to participate in a telehealth consultation. I understand that some parts of the exam involving tests may be conducted by individuals at my location at the direction of the service provider. I may choose to stop any telehealth session or withdraw my consent to telehealth services at any time. This consent will expire in one (1) year from the signature date on this form.

6. In an emergent situation, I understand that my telehealth healthcare provider may discontinue the visit, and a face-to-face visit with a healthcare provider will be initiated at my physical location.

7. My nurse or healthcare provider at the physical location will complete my visit with the telehealth provider by providing me with patient education, prescriptions, laboratory orders, or any recommended correspondence.

I elect (Check all that apply): [ ] A telephone consult [ ] A video consult

I may call 1-225-925-1906 or 1-866-628-2133 to reach a clinical provider.

My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify that: 1.) That I have read or had this form read and/or had this form explained to me, 2.) I fully understand its contents including the risks and benefits of the procedure(s), and 3.) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

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Client Name (Printed) Client Signature Date

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*Personal Representative Name (Printed) *If Needed Personal Representative Signature Date

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Witness Name (Printed) Witness Signature Date