BEHAVIORAL HEALTH SERVICES TELEHEALTH INFORMED CONSENT/AGREEMENT
(Client at non-CAHSD Location)

- I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a healthcare, mental health, or substance abuse treatment provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to receiving services provided to me via telehealth over secure video conferencing platform.
- If applicable, I understand that I am also consenting to group therapy services via telehealth.
- I understand that the laws that protect privacy and the confidentiality of my protected health information also apply to telehealth or teletherapy.
- I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.
- I understand that there are potential risks involving technology including and not limited to internet interruptions and technical difficulties.
- I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.
- I understand that I am responsible for information security on my computer and in my own physical location.
- I understand that I am responsible for creating and maintaining my username and password and not sharing these with another person.
- I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.
- I understand that my health care provider or I can discontinue the telehealth or teletherapy services if it is felt that this type of service delivery does not benefit my needs.
- I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my provider, and all of my questions have been answered to my satisfaction.
- I hereby give my informed consent for the use of telehealth or teletherapy in my care.

Client Name (Printed)	Client Signature	Date
*Parent/Legal Guardian Name (Printed) *If Needed	Parent/Legal Guardian Signature	Date
*Personal Representative Name (Printed) *If Needed	Personal Representative Signature	Date
Witness Name (Printed)	Witness Signature	Date