Child/Minor Consent Form Packet

First Name (Client/Patient)* | M.I. | Last Name* | Date of Birth*
MM/DD/YYYY

Introduction

Telehealth includes teletherapy and telemedicine, allowing patients to access therapeutic and psychiatric care using audio-video interfaces such as video conferencing. Electronic systems used at CHS incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data. They also include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits

- Improved access to psychiatric care and therapy
- More efficient psychiatric evaluation and management
- Obtaining expertise of a distant specialist

Possible Risks

The potential risks associated with the use of teletherapy include, but may not be limited to the following:

- Information transmitted (e.g., visual images, sound) may not be sufficient to allow for appropriate assessment by therapist or prescriber
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment or associated software
- Security protocols could fail, causing a breach of privacy of personal health information
- Limited access to medical records may result in adverse drug interactions, allergic reactions, or other medication management errors

Such risks are generally rare if tools of technology are maintained and staff is trained in their use for the benefit of patient care.

National Emergency Crisis: Consent to telehealth services

I understand that due to the COVID-19 related national emergency crisis, telehealth is offered by CHS to appropriate patients. This is an effort to comply with federal and state mandates of isolation and social distancing while providing continuity of patient care that keeps everyone safe and protected.

Signature of Client/Patient/Legal Guardian*

[Clear]

By signing this form, I understand the following

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy, and that no information obtained in the use of teletherapy which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained in the course of a teletherapy interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of psychiatric and therapeutic care may be available to me, and that I may choose one or more of these at any time.
- I understand that it is my duty to inform my psychiatrist and/or therapist of any other healthcare providers involved in my therapeutic/psychiatric care.
- I understand that I may expect the anticipated benefits from the use of teletherapy in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Teletherapy

I have read and understand the information provided above regarding teletherapy, have discussed it with my psychiatrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of teletherapy in my medical care.

Please note: Any co-pay, co-insurance or deductibles due for the date of service will still be client responsibility.

I hereby authorize Comprehensive Health Services to use teletherapy in the course of my diagnosis and treatment.

Signature of Client/Patient/Legal Guardian* | If authorized signer, relationship to patient

Witness

Date
MM/DD/YYYY

[Clear]

Date of Signature*
MM/DD/YYYY