Caudill
Counseling Center
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TELEHEALTH INFORMED CONSENT

I _____ (patient name) hereby consent to participate in telehealth via the Skype platform at Caudill Counseling Center. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, using interactive audio, video, and data communications.

Technology: I understand that I am responsible for

1. Having a broadband internet connection or a smart phone device with a good cellular/internet connection.
2. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions.
3. Providing the clinician my full name and date of birth to confirm my identity at the beginning of each session.
4. Providing the clinician the address of my location and the phone number I can be contacted at.

Financial Obligations: I understand that I am responsible for cancelled and/or missed telehealth appointments in accordance with the Caudill Counseling Center no-show/cancellation policy as documented by my signature. By signing this form, I understand and agree to abide by all financial obligations further described in my New Patient Paperwork which I have signed.

Scheduling: I understand that scheduling is conducted through Caudill Counseling Center. If a person other than the client is present during the session, it must be discussed and agreed upon prior to the telehealth appointment. Telehealth appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice Caudill Counseling Center DOES NOT record Telehealth sessions. If it is deemed necessary, written consent will be obtained from the client first.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withdraw my consent at any time without affecting my right to future care or treatment.
2. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video/audio conferencing technology. I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my counselor that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services.
3. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
4. I understand that Caudill Counseling Center cannot provide telehealth services to me if I am outside of the State of Kentucky. I understand that I may access telehealth services from Caudill Counseling Center from within the State of Kentucky only. I have read and understand the information provided above. I understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

My signature below indicates my informed and willful consent to treatment using the Skype platform. A photocopy of this consent form is to be considered as valid as the original.

PLEASE PRINT AND SIGN

_____ _____ Print Patient Name

Date

_____ _____ Signature

Date