Kentucky Telehealth
TELEMENTAL HEALTH INFORMED CONSENT FORM

CLIENT INFORMATION

Client Name:_____ Provider Seeing Client Via Telehealth_____

DOB:_____ Provider Location: _BOWLING GREEN_____

Site/State Where Client is Seen Via Telehealth:___KENTUCKY_____

INFORMATION

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you. Since 1994, the technology has connected tens of thousands of clients and providers in Kentucky. The information be used in diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a client to remain within the facility and obtain serves from providers at distant sites.
- Client remains closer to home where local health care providers can maintain continuity of care.
- Reduced need to travel for the client or the provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemental health staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to ensure this videoconference is secure and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemental health which include, but may not be limited to:

- A provider may determine that the telemental health encounter is not yielding sufficient information to man an appropriate clinical decision.
- Technology problems may delay the mental health evaluation for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I Understand the Following:

1. I understand that the laws that protect privacy and confidentially of medical information also apply to telemental health and that no information obtained in the use of telemental health which identifies me will be identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to Wilson Counseling, LLC for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

Client Consent to the Use of Telemental Health:

I have read and understand the information provided above regarding telemental health and all of my questions have been answered to my satisfaction. I Herby give my informed consent for the use of telemental health in my care.

I hearby authorize **Wilson Counseling** to use telemental health in the course of my diagnosis and treatment.

Signature of Client (or authorized person) _____ Date_____

If authorized signer, relationship to client_____Date_____

Clinician Signature_____Date_____