HWC INFORMED CONSENT FOR ONLINE THERAPY

Client/Patient's Name:_____ Birthdate: _____

Email: _____ Phone:_____

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

1) My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2) I understand that therapy conducted online is technical in nature and that problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected.
    a) I understand there are potential risks to this technology (as listed above, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
    b) If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I agree to call, message, or email my therapist back via the telehealth platform or contact the Hope and Wellness Center office at 402-639-2901.

3) I understand I have the right/option to refuse the telehealth consultation/session/appointment at any time without affecting my right as a client/patient to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled;

4) I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to

access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

5) I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. This signed statement will become part of the medical record.
    a) I understand as a client, I have access to all medical information resulting from the telehealth consultation as provided by law for access to my medical records.
    b) I understand the dissemination of any client/patient identifiable images or information from the telehealth consultation to researchers or other entities shall not occur without my written consent.

_____

Patient/Client Signature Date

_____

Parent, Guardian or Legal Representative Signature (if minor or needed otherwise) Date

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