Patient Name:
DOB:
MR #:

**Associated Physicians, LLP**

# BEHAVIORAL HEALTH TELEHEALTH INFORMED CONSENT TO TREATMENT

Index to Consent – Treatment/Procedures – Behavioral Health

Date: _____

I hereby consent to participate in tele-behavioral health with Associated Physicians Behavioral Health team, as part of my psychotherapy. I understand that tele-behavioral health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand that I may have a behavioral health condition that may require treatment. I consent to the proposed evaluation and/or treatment provided at Associated Physicians, LLP – Behavioral Health. I understand that the services available to me may include but are not limited to:

- evaluation,
- diagnosis,
- treatment planning,
- individual and group counseling,
- medicine,
- family counseling,
- education, and
- treatment discharge planning and referral.

I understand the following with respect to tele-behavioral health:

- I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- I understand that there are risks, benefits, and consequences associated with tele-behavioral health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-behavioral health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

  I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-behavioral health services are not appropriate, and a higher level of care is required
- I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
- I understand that during a tele-behavioral health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at_____ to discuss since we may have to re-schedule.

I understand my rights, including my right to withdraw my consent in writing at any time. I have been offered a copy of those rights. I understand the clinic's grievance procedure and have been offered a copy.

**Emergency Protocols** I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my location is:

_____
_____

and my emergency contact person's name, address, phone:

_____
_____

I have read and understand all the information given to me. I have been given enough time to ask questions or get more information and to get answers to my questions. The risks and benefits of the treatment and other treatment options have been made clear to me. I have been told what may happen if I do not have treatment. The information provided to me is specific, accurate and complete. I consent to evaluation and treatment at Associated Physicians, LLP – Behavioral Health.
**This consent expires 15 months from the date of my signature below, upon my discharge from treatment, or when I give written notice that my consent is terminated (if earlier than 15 months from the date of my signature).**

I may request and receive a copy of this consent.

I have been given the information to verify my benefits and prior authorization needs for these services. I agree to notify Associated Physicians, LLP of any prior authorization or benefit requirements needing to be done before my appointment for coverage, otherwise I may be responsible for the charges

☐ ***(Checking this box means you agree to these terms above)***

**AUTHORIZING SIGNATURES**

Signature of Patient/Representative_____Date:____/____/____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do to.

Print Name:_____Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated

Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ Other: _____

Provider Signature:_____Print Provider Name: Gil Roth, LCSW, SAC

Date:____/____/____Time:_____