PATIENT CONSENT FOR TELEBEHAVIORAL HEALTHCARE SERVICES

1) I understand that my local healthcare or behavioral provider has asked a specialist to assist with my behavioral healthcare services. The specialist will see me through a live, private video. My local providers have asked for assistance that is not available in my community. I understand that my local providers and I will still make the decisions about what treatment I may or may not receive.

2) I understand that because this is a telebehavioral health appointment, it may sometimes be necessary for someone who works with the specialists to monitor the video to make sure the equipment is working. All staff will keep my information confidential.

3) I understand that my local provider will schedule appointments with the specialist. The specialist will only be available during the scheduled appointment times. I will need to contact my local provider with urgent concerns. I understand that I will need to contact my local healthcare emergency provider for emergencies.

4) I understand that this service is completely voluntary and that I can choose not to answer questions at any time. I may stop participating at any time.

5) I understand that the specialist cannot physically examine me, nor physically intervene if needed for my health, and that only my local providers can provide such services to me.

6) I understand that none of the services provided will be recorded or photographed unless I am asked and agree.

7) I understand that my local health care medical records will contain a copy of this consultation, and that my local health care providers will work with me on the treatment plan for my mental health and substance abuse needs.

8) I understand that I have a choice to allow anyone else to be present here or at the specialist site during my appointments. However, I understand that the specialist may need the local provider to sit in the room to assist with my services.

9) I understand that I may be contacted after my appointment so the Daylight Partnership can ask me about the quality of the services I received. I may be asked to give my opinion of the services I received and asked for suggestions about how it can be done better in the future.

10) I agree to the telemedicine service described above. I agree that all of my questions have been answered about the telebehavioral healthcare service.

Signature: ____ Date: _____________

(Patient/Legal Guardian)

Patient name (please print): ____

Witness signature: _______________________________________