SIOUXLAND CHILD & ADOLESCENT THERAPY SERVICES, LLC

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TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telehealth at Siouxland Child & Adolescent Therapy Services, LLC as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical and mental health data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in South Dakota.

Technology: I understand that I may need to download an application and/or software to use telehealth. I also may need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Siouxland Child & Adolescent Therapy Services, LLC via phone to coordinate alternative methods of treatment.

Scheduling: I understand that scheduling is conducted through Siouxland Child & Adolescent Therapy Services, LLC and is based on my psychologist's, counselor's or social worker's normal clinic hours. 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 practice Siouxland Child & Adolescent Therapy Services, LLC **DOES NOT** record Telehealth sessions without prior permission. By signing this document, you also agree to not record any Telehealth sessions.

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

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of non-forensic sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to: reporting physical abuse, sexual abuse, or neglect of persons less than 18 years of age and/or vulnerable adults; expressed threats of violence toward an ascertainable victim; where I make my mental or emotional state an issue in a legal proceeding; instances where the court shall order the disclosure of otherwise privileged information; in response to a subpoena for these records. When forensic assessments or treatment are provided, information will typically be shared with the appropriate third party to include but not limited to a court, an attorney, social services, a school district, another mental health or medical provider, with your informed consent. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

   Concerning informed consent for minors, while parents and guardians have a right to know general information about how therapy with their child is progressing, in signing this form you waive the right to know the private details of the child's therapy, or to have access to the confidential therapy records of the child. A general summary can be provided at any time upon request.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychologist, counselor or social worker, that: there could be a lack of adequate privacy at the client's telehealth location; the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Siouxland Child & Adolescent Therapy Services, LLC typically utilizes secure, encrypted audio/video transmission software to deliver telehealth when possible. Exceptions may be made during national or state emergencies, to include during pandemics, with your consent

4. I understand that if my psychologist, counselor or social worker believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, counselor or social worker, my condition may not improve, and in some cases may even get worse.

5. 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 conferencing technology. I also understand that at my request or at the direction of my psychologist, counselor or social worker, I may be directed to “face-to face” psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my psychologist, counselor or social worker in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.

8. I understand that my express consent is required to forward my personally identifiable information to a third party.

9. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

10. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

11. I understand that different states have different regulations for the use of telehealth. In South Dakota, telehealth may at times only be conducted between certified office locations. I understand that, in South Dakota, I may not able to connect from an alternative location for the provision of audio-/video-/computer based psychotherapy services, with there being possible exceptions during national and/or state emergencies.

Financial Obligations for Telehealth Services

Siouxland Child & Adolescent Therapy Services, LLC will bill insurance or other third party for telehealth services when these services have been determined to be covered by an individual's insurance plan or third party. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, payment at the time of service is required. We will provide you with a statement of service to submit to your insurance company if you wish. I authorize insurance benefits to be paid directly to Siouxland Child & Adolescent Therapy Services, LLC and that Siouxland Child & Adolescent Therapy Services, LLC may release any information to my insurance provider required for processing my claims.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my psychologist, counselor, or social worker and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

Please provide the information requested below, and by my signature I hereby state that I have read, understand, and agree to the terms of this document.

_____ _____

Print Name Telephone #

_____

Email Address

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Signature Date

_____ _____

Siouxland Child & Adolescent Therapy Services, LLC Provider Signature Verifying Staff and Patient Review of Telehealth Informed Consent

Date