Emergence Health Network
El Paso Center for Mental Health/Intellectual Disabilities

Client#/Case#:

Medicaid #:

Unit:

Consent to Participate in Telehealth/Telemedicine Treatment

Client Name: Time:

1. I understand the telehealth/telemedicine services are optional and may not be appropriate for every session or situation.
2. It has been explained to me how the video conferencing technology will be used.
3. I understand that this treatment service will not be the same as a direct client/therapist/ or doctor visit since I will not be in the same room as the therapist or doctor.
4. I understand there are potential risks to this technology including:
    - Delays in services provided may occur due to deficiencies or failure of equipment.
    - Information transmitted may not be sufficient (e.g. poor resolution of video) to allow for appropriate service decision making by the therapist or doctor.
    - A lack of access to all the information that might be available in a face-to-face visit but not in a telehealth session may result in errors in service judgment.
    - I understand that the therapist, doctor, or myself can discontinue telehealth treatment and may result in errors in service judgment.
    - I understand that the therapist, doctor, or myself can discontinue the telehealth consult/visit if it is felt that the video conferencing connections are not adequate for the situation, or it is felt that the client requires a face to face evaluation with the therapist or doctor and the client in the same room.

I understand that there are benefits to using telehealth including:

- Client convenience
- Increased accessibility to services where a therapist or doctor may not normally be available.
- Ability to see a therapist or doctor without the need to make travel arrangements to get to an Emergence Health Network Office.
- In some cases, clients may be more comfortable talking to a therapist or doctor over telehealth than in the same room.

I understand that my healthcare information may be shared with other individuals at my institution for scheduling purposes and video equipment operations. The above-mentioned people will contain confidentiality of the information obtained. I further understand that I will be informed of their presence in the situation and thus will have the right to request the following: (1) omit specific details of my treatment that are personally sensitive to me; (2) ask non-essential personnel to leave the telehealth room; and/or (3) terminate the screening/assessment at any time.

I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in this process.

I understand that the treatment will not be recorded or photographed.

I understand that the responsibility of facility's designated staff is to advise the therapist or doctor and that his/her responsibility will conclude upon the termination of the video conference connection.

I have read this document carefully, and understand the risks and benefits of treatment and I have asked my questions regarding the procedure explained and I hereby consent to participate in a telehealth visit and terms described here in.

☐ Verbal consent to participate in telehealth/telemedicine was given by the consumer due to Covid 19. Consumer was able to understand what to expect from telehealth/telemedicine and their rights.

Signature (patient or LAR): _____

Witness: _____