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Behavioral Telehealth Informed Consent Form

I	(name of ADULT patient 18 or older) agree and consent to receiving
behavioral telehealth services provide	ed by Great Changes Counseling Services
OR	
I am the legal guardian of	(name of minor patient, under 18)
and as such I am agreeing and consen	ting to his/her participation in behavioral telehealth services offered and provided
by Great Changes Counseling Services	
I understand that "behavioral telehea	Ith" includes the practice of health care delivery, diagnosis, consultation,

I understand the following information & rights with respect to behavioral telehealth:

treatment, and education using interactive audio, video, or data communications.

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- I understand that none of the behavioral telehealth sessions will be recorded or photographed without my written permission
- I understand that behavioral telehealth is performed over a secure communication system that is designed to prevent unauthorized access. Despite this, I accept that protection against the very rare occurrence of a breach of confidential information cannot be guaranteed.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that me or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist.
- I understand that my therapist is licensed to practice ONLY in the State of IL and that I may only receive telehealth services while I am physically located in IL. My therapist may NOT conduct telehealth while I am out of state on vacation or on a business trip, etc.
- The laws that protect the confidentiality of my medical and mental health information also apply to behavioral telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child, elder, and dependent adult abuse; and expressed threats of violence towards self and/or an ascertainable victim.
- I understand that I may need to install applications for behavioral telehealth services onto my phone, tablet or computer device.
- My therapist has explained to me how video conferencing technology will be used. I understand that any
 telehealth sessions will not be the same as an in-person session since I will not be in the same room as my
 therapist
- I understand that it is important to be in a quiet, private place that is free of distractions for the sessions.
- It is important to use a secure internet connection rather than public or free Wi-Fi.
- I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.

- I understand that if there is an emergency during a telehealth session, then my therapist will call emergency services and my emergency contacts.
- I understand that I am required to provide a safety plan that is shared with my therapist in case of an emergency (see below)
- You should confirm with your insurance company that Behavioral Telehealth sessions will be covered. If your insurance does not reimburse for Behavioral Telehealth, you are responsible for full payment.
- Your treatment provider may determine that due to certain circumstances, Behavioral Telehealth is no longer appropriate. Decisions will be made about referral or continuing treatment with face-to-face sessions.

natures:				
	Patient or Parent of Minor Patient	Date		
	Therapist	Date		
	Behavioral T	elehealth Safety F	Plan Addendum	
Patient Name (first and last):			Patient Date of Birth	
	l Address of Patient during telehealth			
Street:		City:	State:	Zip:
	s Phone Number:			
	Number: City/S			
	ency Contact (2):			
Phone I	Number: City/S	tate:		
	ospital (local to telehealth location of Number:	client):		
	• I have provided two emergency as deemed appropriate.	contact numbers and th	ne number to the loc	al hospital or other facil
	 If there is an emergency during a contacts and the local hospital. 	a session, my therapist	has permission to co	ntact my emergency
	 I have provided a working teleph during a session. 	none number to reach r	ne if the video confe	rencing connection fails
	 My therapist has provided me w me back within 5 minutes, then 		f connections fail and	d my counselor does not
Signatu	res:Patient or Parent of Minor Patien			
			Date 	_
	Therapist		Date	