Behavioral Health Providers, P.C.

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INFORMED CONSENT FOR TELEVISITS

PATIENT NAME: ____

I, the undersigned, agree to participate in video conferenced visits (Televisits) with Behavioral Health Providers, PC. This means that I authorize information related to my health care to be securely electronically transmitted in the form of images and data through an interactive video connection to and from the above-named psychologist and other persons involved in my health care.

Location: I understand that I must conduct such visits from a private setting where I will not be interrupted.

Equipment: I will understand I must be connected to a secure network or connection. I agree to use only my own equipment for Televisits and will not use my employer's computer or network for the visit.

Identification: I understand that I may be asked to supply information to verify my identity prior to the visit proceeding. If other parties are present during the Televisit, they will also be identified and their purpose for attending the meeting will be clarified.

Nature of Televisit: My psychologist/therapist has explained how the Televisit is performed and how it will be used for my treatment. My psychologist/therapist has also explained how the Televisit will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Possible Risks: Risks that have been recognized include, but may not be limited to:

1. It is possible that the technology will fail before or during the Televisit.
2. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images or poor audio) to allow for appropriate decision making by your clinician.
3. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Expected Benefits: I understand that some of the potential benefits of a Televisit include, but are not limited to:

1. Improved access to care.
2. More efficient evaluation and management.
3. Reduced travel time and cost.
4. Easier availability.

Discontinuation. I understand that a Televisit can be discontinued at any time, either by me or by my psychologist/therapist. I further understand that I do not have to answer any questions that I feel are inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate in the Televisit will not affect my continued treatment, and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or could fail entirely.

Alternatives. The alternatives to the Televisits have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person visits and that a Televisit does not necessarily eliminate my need to see my psychologist/therapist in person, and I have received no guarantee as to the Televisit's effectiveness.

Follow-Up Care. When, for whatever reason, a Televisit is unable to provide all the necessary clinical information that my psychologist/therapist believes is necessary to properly evaluate me, prior to the conclusion of the Televisit, I will be informed of the need for an in-person evaluation. If I have an adverse reaction to the treatment or in the event of an inability to communicate because of technological or equipment failure, I will be informed of how I can receive follow-up care.

Records. I understand that my Televisit may be recorded and stored electronically as part of my clinical record. I understand that Televisits, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my clinical records in accordance to Illinois law and that copies of records of Televisits are available to me

upon my written request. I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy

Contact Information: I have received a copy of my psychologist/therapist's contact information, including their full name, telephone number, and physical address. I have also been provided with a list of local support services in case of an emergency. I am aware that my psychologist/therapist may contact the proper authorities in case of an emergency. I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation, I am NOT to seek a Televisit. Instead, I will seek care immediately through my own physician, the nearest hospital emergency department, or by calling 911.

Release from Liability. I unconditionally release and discharge Behavioral Health Providers, PC, and their affiliates, agents, employees; and designees from any liability in connection with my participation in remote Televisits

Ethics and Professional Standards: Behavioral Health Providers, PC and its affiliates are licensed clinicians regulated by the State Board of Examiners and is accountable for their work with you. I understand that if I have any concerns about my care, my psychologist/therapist or their supervisor would be happy to discuss them with me. I can contact them using the contact information listed above.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the videoconference visits (Televisit), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Patient Signature

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Guardian Signature (if patient is a minor)

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Date________________