

Telehealth Informed Consent

Becker Counseling Services, LLC
8424 West Center Road, Suite 214
Omaha, NE 68124
Telephone: (402) 983-2877 Fax: (402) 939-0172

I, _____, agree to receive medically necessary live, interactive video telehealth services from Becker Counseling Services, LLC, who is located a distant site location, for mental health therapy. This distant site may be at the following locations: 7720 South 93rd Street, La Vista, Ne 68128, 4817 North 133rd Plz #1031, Omaha, Ne, 68164, or 8424 West Center Road, Suite 214, Omaha, Ne, 68124.

I, _____, understand that:

- A. I retain the right to refuse telehealth consultations at any time without affecting my right to future care or treatment without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- B. All existing confidentiality protections shall apply to my telehealth consultation.
- C. I shall have access to all medical information resulting from telehealth consultation, as provided by law.
- D. Information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
- E. If I decline telehealth services, other alternative options are available to me, including in-person services. These options are: Meeting at the onsite location at 8424 West Center Road, Suite 214, Omaha, Ne 68124.
- F. I will be informed whether the telehealth consultation will be or will not be recorded.
- G. I will be informed of all people who will be present at all sites during my telehealth service.
- H. I retain the right to exclude anyone from either the originating or distant site.
- I. I understand that this consent is valid for six months for follow-up telehealth services with this health care provider.
- J. I may see an appropriately trained staff person in-person immediately after the telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.

I have read this document carefully and my questions have been answered to my satisfaction.

Signature of Client

Date

Signature of Legal Authorized Representative

Date

Signature of Health Care Practitioner Obtaining Consent

Date