TRUE NORTH COUNSELING, LLC

Find your inner compass

Client Consent to Treat with Tele-Health

I understand that my health care provider wishes me to engage in a telehealth consultation.

I understand video conferencing technology will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Telehealth is the technology service we will use to conduct telehealth videoconferencing appointments. By signing this document, I acknowledge:

Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911 or go to the nearest emergency room.

I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.

If I decline telehealth services and the therapist is only providing telehealth services, a referral for another provider doing in-person therapy can be provided.

I may have to travel to see a health care practitioner in-person if I decline the telehealth service.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

The same confidentiality protections which apply to my other medical care also apply to the telehealth services.

I will have access to all medical information resulting from telehealth service as provided by law.

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Omaha, NE 68137
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The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth services) cannot be released to researchers or anyone without my additional written consent.

I will be informed of all people and will inform the practitioner who will be present at all sites during my telehealth service.

I may see an appropriately trained staff person or employee in-person immediately after the telehealth services if an urgent need arises OR I will be told ahead of time that this is not available.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedures.

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature of Client/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____

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