Lakeview BEHAVIORAL HEALTH

PATIENT IDENTIFICATION STICKER

CONSENT FOR TELE-HEALTH and USE OF ELECTRONIC MEDIA

The use of electronic media communication to treat the needs of a health care client, sometimes referred to as "telemedicine" or "telehealth," means that the practice of health care delivery, diagnosis, consultation, treatment, transfer of health data, and education using interactive audio, video, or data communications. Examples of these types of communications include the use of, but are not limited to the use of: electronic mail, cell/mobile/VoIP calls, voicemail, text messaging, video conferencing, social media sites, and other non-face-to-face interactions.

By selecting and signing below, you acknowledge that there are logistical and privacy issues that may or may not be compromised in the use of electronic media communication systems. Lakeview Behavioral Health ("Provider") will continue to abide by the privacy and confidentiality standards. Please review the following section for additional information regarding the risks and benefits of using electronic media communication for evaluation, treatment and behavioral health therapy.

1) You, (the "Client/Patient"), retain the option to withhold or withdraw consent to the use of electronic media communication at any time without affecting the right to future care or treatment and without risking the loss of withdrawal of any program benefits to which you would otherwise be entitled.
2) The risks involved with the use of electronic media communication include, but are not limited to:
   a. There is the risk of the potential release of private information due to the complexities and abnormalities involved with the use of Internet. Viruses, Trojan horses, and other involuntary intrusions have the ability to intercept communications, resulting in the release information that you may desire to keep private.
   b. The risk of being overheard by anyone near you if you do not place yourself in a private area.
   c. Health care services and care provided through the use of electronic media communications may not be as complete as care or services provided in a face-to-face setting and there may be misunderstandings due to the lack of visual cues that might be absent from the transmission.
   d. There may be technical or service-related issues impacting transmission that, despite reasonable efforts on the part of Provider, that may result in a disrupted or distorted transmission of information.
3) There are benefits to using electronic media communication that should be weighed against the risks, including, but not limited to, the benefit of not having to travel to obtain therapy services that might otherwise not be available due to the distance or the expense of having to travel to obtain the services, and the comfort of being able to obtain services in a familiar home setting.
4) All existing confidentiality protections apply for your privacy and confidentiality.

ACKNOWLEDGMENT OF THE RISKS AND BENEFITS OF THE USE OF ELECTRONIC MEDIA COMMUNICATION

I have read the Consent and have chosen the following method of communication in the event that I schedule to speak to a physician, nurse practitioner, or clinician using electronic media: _____Video conferencing; _____Telephonic (cell phone, text messaging, voice-mail): _____Electronic mail; _____No preference; _____I do not wish to participate

By signing this form, I understand the following

- I understand that there are both risks and benefits, as mentioned within this consent form, as well as others that I may not fully be aware of that can occur with or without our knowledge.
- I understand that Provider will use its best efforts to protect personal information and abide by all relevant privacy and confidentiality laws and regulations.
- I will use my best efforts to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information.
- I understand that there are no universal protocols or protective standards in the use of electronic media communication and that I will hold Provider, its employees, agents, and officers, harmless and free from any liability in the event I use this method of communication and engage my therapist to receive communication in this manner.
- I agree that Provider verbally informed me of the risks and benefits of using electronic media communication, in addition to providing me with the information in this written Consent Form.

PATIENT/CLIENT SIGNATURE OR REPRESENTATIVE: _____ Date: _____ Time: _____

RELATIONSHIP TO PATIENT/CLIENT: _____

WITNESS SIGNATURE: _____ Date: _____ Time: _____

REVOCATION OF CONSENT TO THE USE OF TEL-HEALTH AND ELECTRONIC MEDIA COMMUNICATION I, _____, revoke my prior consent to the use of electronic media communication as a means of therapy.

OFFICE USE ONLY:

☐ PHP APPLICABLE DATE(S) OF SERVICE: _____

☐ IOP APPLICABLE DATE(S) OF SERVICE: _____

Staff Initial _____ Date: _____