

Lifepath Counseling & Wellness
(208)780-3900

Telehealth Informed Consent

Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals (“Treatment Providers”) at different locations to share individual client medical information for the purpose of improving client care.

Treatment Providers may include, but are not limited to psychiatrists, psychologists, nurse practitioners, counselors, clinical social workers, and marriage and family therapists.

The information may be used for healthcare delivery, diagnosis, treatment, transfer of medical data, therapy, coordination of care, follow-up and/or education, and may include any of the following: Live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

The telehealth provider will initiate the contact at time session is scheduled.

Since this may be different than the type of treatment with which you are familiar, it is important that you understand and agree to the following statements.

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to information demonstrating a probability of imminent physical injury to myself or others; immediate mental or emotional injury to myself; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to researchers or other entities shall not occur without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a Telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. I understand that I may ask my Treatment Provider about alternative methods of care to Telehealth.
5. I understand that it is my duty to inform my Treatment Provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that Telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my Treatment Provider believes I would be better served by another form of service (e.g. face-to-face services), I will be referred to a Treatment Provider who can provide such services in my area.
7. I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Treatment Provider, my condition may not improve, and in some cases may even get worse.
8. I understand that I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.
9. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider and call the Lifepath line at **(208)780-3900**.

Expected Benefits

1. Improved access to medical care by enabling a client to remain at a remote site while the Treatment Provider obtains test results and consults from healthcare practitioners at distant/other sites.
2. More efficient evaluation and management for continuity of care.
3. Obtaining the expertise of a distant specialist as rapport has been developed.

Possible Risks

1. Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Treatment Provider and consultant(s).

2. Delays in medical evaluation and treatment could occur due to technical deficiencies or failures.
3. The transmission of Client's medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Necessity of In-Person Evaluation

If it becomes clear that the Telehealth modality is unable to provide all pertinent clinical information during a particular Telehealth encounter, the Treatment Provider must make it known to the client prior to the conclusion of the live Telehealth encounter. The Treatment Provider must also counsel the client prior to the conclusion of the live Telehealth encounter regarding the need for the client to obtain an additional in-person evaluation reasonably able to meet the client's needs.

Platform:

Lifepath Counseling & Wellness uses but is not limited to Zoom and [Doxy.me](https://www.doxy.me). The platforms that Lifepath Counseling & Wellness uses may change and be updated throughout treatment.

In cases of emergency

Call 911 immediately

Or backup support person (208)780-3900

Complaints against Treatment Providers: or other health care providers, may be reported for investigation to the Medical Board or other appropriate licensing board of the state in which client received the services.

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding Telehealth and understand I have the opportunity to discuss it with my Treatment Provider or such assistants as may be designated. I hereby give my informed consent for the use of Telehealth in my medical care. Furthermore, I agree that the Released Parties have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.

I hereby authorize **Lifepath Counseling & Wellness** to use “Telehealth” in the course of my diagnosis and treatment.

I have read and understand and/or obtained a copy (at my request) of documentation explaining the Telehealth guidelines that Lifepath Counseling & Wellness Telehealth providers adhere to.

X

Client Signature

Date