Lutheran Family Services of Nebraska, Inc. www.LFSneb.org

TeleHealth Service Consent

Client Name	Initials	Date of Birth	EHR/Client Number
_____	_____	___/___/___	_____

TeleHealth services allow me to receive treatment from a practitioner at a distance using an encrypted web-based platform. TeleHealth services may complement my treatment or be my primary method of participation.

I also understand that:

- 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.
- I may have to travel to see a behavioral health practitioner in-person if I decline the TeleHeath service.
- If I decline the TeleHealth service, I will be informed of the other options/alternatives available for me, including in-person services, are as follows: seek alternative providers in your community.
- I understand that my provider may request that I participate in an occasional in-person session or consult with a local health care provider in my community as part of my treatment.
- I understand that if TeleHealth services become unsuitable for any reason, I may be referred to another provider or service.
- The same confidentiality protections that apply to my other behavioral health services also apply to the TeleHealth service. I understand that I am responsible for ensuring my own privacy in the location from which I choose to participate in TeleHealth services.
- I will have access to all information resulting from the TeleHealth service as provided by law.
- I will be informed of all people who will be present at all sites during my TeleHealth service. I may request that students or other observers be excluded from my TeleHealth session.
- The 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 additional written consent.
- If an urgent need arises during a TeleHealth session, I understand that my practitioner may refer me to an appropriate emergency service or request an emergency response, to my location, on my behalf.
- I understand that I must physically be in the state(s) of _____ during my telehealth session as my therapist is licensed to provide services in the state(s) listed above.

The undersigned certifies that he or she has read and understands the above mentioned and is the client, client's guardian, power of attorney, parent, or is duly authorized by or on behalf of the client to execute the above and accept its terms.

Signature of Client or Guardian	Relationship to Client	Date
_____	_____	___/___/___

Signature of LFS Staff	Title	Date
_____	_____	___/___/___

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