LINCOLN FAMILY MEDICAL GROUP, P.C.
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Telehealth Informed Consent

1. Client Name: _____ Date of Birth: _____ Date: _____

I understand that I will be receiving mental health services through telehealth (video and/or telephone) instead of meeting in person. By signing below, I acknowledge that:

1. I understand the nature and purpose of telehealth and have had the opportunity to ask questions.
2. I understand that telehealth has benefits (greater convenience and access) as well as risks, including technical problems and the potential for privacy limitations.
3. I understand that confidentiality is protected to the extent required by law, although no electronic communication system can guarantee complete security.
4. I agree to participate from a private location whenever possible and understand that my provider will also take reasonable steps to protect my privacy.
5. I understand that I may stop telehealth services or request in-person services (when available and clinically appropriate) at any time.
6. I understand that telehealth is not appropriate for emergencies. If I am experiencing a mental health or medical emergency, I will call 911 or go to the nearest emergency room. I may also contact 988 for Suicide & Crisis Lifeline.
7. I agree to provide my current physical location and a working phone number at the beginning of each telehealth session so my provider can respond appropriately in case of an emergency.
8. I understand that my provider may determine that telehealth is not appropriate for my needs and may recommend an in-person visit or another level of care.

I have read and understand this information and voluntarily consent to receive behavioral health services through telehealth.

2. Printed Name of Signer: _____ Relationship to Client: _____ Date: _____

Client Signature (Parent/Guardian if applicable)

_____
Signature