Blysss Behavioral Health

Telehealth Consent Form

Some clients may be obtaining services via telehealth. Telehealth includes psychiatric behavioral health evaluation, diagnosis, and treatment, medical management, psychotherapy delivery, consultation, transfer of medical data, and education using interactive audio, video, or data communications. Telehealth services enable clients to receive services in place of and or where physical services are not an option. However, there are potential risks associated with the use of telehealth including but not limited to, the possibility, despite reasonable efforts on the part of the provider or therapist, that: the process of providing psychiatric behavioral health services via telehealth services could be disrupted or distorted by technological failures; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of medical information could be accessed by unauthorized persons. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand that I have the Following Rights with Respect to Telehealth: (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. (2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; 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 other entities shall not occur without my written consent. (3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of intervention (e.g., face-to-face services), I will be scheduled for a face-to-face appointment with a Blysss Behavioral Health provider or therapist. Finally, I understand that there are potential risks and benefits associated with behavioral health intervention and that despite the efforts of my provider or therapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telehealth behavioral health interventions, but that results cannot be guaranteed or assured. (4) I understand that the use of the video software may at times have issues with Wi-Fi connectivity. All attempts to keep information confidential while using this system will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with communication systems. Signing this form shows an awareness of 1 these issues and a decision by this client to use this system for video conferencing. I will not hold Blysss Behavioral Health, PLLC, Blysss MSO, LLC, Blysss Behavioral Health, PLLC providers, employees, or agents liable for any gathering or use of client information by these service providers. (5) I understand that I have a right to access my personal

information and copies of case records per Illinois law. I have read and understand the information provided above. I have discussed it with my provider and all of my questions have been answered to my satisfaction. (6) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based behavioral health services. I understand that emergency situations include but are not limited to experiencing any of the following: suicidal thoughts, homicidal thoughts, hallucinations, delusions/beliefs that others may consider unrealistic, life-threatening crisis, uncontrollable emotional reactions or dysfunctional behavior due to consumption of alcohol or drugs. If I am in crisis or in an emergency, I should immediately call 911, seek help from the nearest hospital or call the National Suicide Hotline Toll-Free Number at 1-800-784-2433.

By signing this document, the patient consents to the use of Telehealth Mental Health Services I have read and understand the information provided above, have discussed any questions with my provider, and all of my questions have been answered to my satisfaction. Regarding the use of telehealth services, I understand that the clinician will use their best efforts to conceal personal information and abide by HIPAA/PHI standards and 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 hereby give my informed consent to engaging in telehealth mental health services.

Signature_____

Date_____