Consent for Telehealth Treatment

Client Name: _____ Date of Birth: _____

Permanent Address: _____ Phone_____

Email Address: _____

I understand and agree to the following with respect to use of New Day Counseling & Psychiatric Services, Inc. and telehealth services:

1. I understand that telehealth is a health/mental health service provided via interactive audio and video technology while the provider is at a different location than me. Telehealth may be provided by New Day Counseling & Psychiatric Services' licensed professionals.
2. I understand that these telehealth services may involve the communication of my health information, orally and visually, to health care practitioners. Specifically, I understand that telehealth services include, but are not limited to, consultation, treatment, and transfer of health data using interactive audio and video. The laws that protect the confidentiality of my health information apply to these services the same as in-person services. As such, I understand that the information disclosed by me during any telehealth session is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality.
3. I understand that there are risks and consequences of using these services including, but not limited to, the possibility that, despite New Day Counseling & Psychiatric Services, Inc.'s reasonable efforts, the transmission of my health information could be disrupted or distorted by technical failures and/or the transmission of my health information could be intercepted or accessed by unauthorized persons. I agree that telehealth is appropriate for my circumstances despite these risks. I understand that when I receive telehealth services from a location other than at New Day Counseling & Psychiatric Services, Inc., my own device and internet connectivity may impact the quality of the services and that New Day Counseling & Psychiatric Services, Inc. does not have control over my end of the transmission.
4. I understand that telehealth services may not be the same as in-person services, where non-verbal communication (body signals) are readily available to both provider and client. The New Day Counseling & Psychiatric Services, Inc. provider will further discuss this limitation with me should I receive telehealth services.
5. If our telehealth session abruptly terminates, the New Day Counseling & Psychiatric Services, Inc. provider will immediately call me at the number(s) listed above. Together we will either attempt to regain the contact via the telehealth technology or, if unable to do so, either reschedule or finish the service via telephone.

I have read and understand the information provided above. I have asked New Day Counseling & Psychiatric Services, Inc. any questions I had and all of my questions have been answered to my satisfaction. I hereby consent to participate in telehealth services under the terms described above.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____