CATALYST
HEALTH & WELLNESS

TELEMEDICINE INFORMED CONSENT FORM for Behavioral Health Services

Name of Client (If a minor) _____

Medical/Insurance Card Number _____

Date of Birth _____

Relationship to Applicant (if a minor) _____

Provider Name Seeing Patient via Telehealth: _____

Provider Location: _____

I understand that the Behavioral Health Department is operated by staff who are Licensed or Licensed but under supervision of a Licensed Therapist to practice in the state of Kentucky. I further understand that staff who are not licensed or independent practice receive supervision by independently licensed staff according to applicable state guidelines. I also understand that in some cases Catalyst staff are composed of practicum or intern students who are pursuing advanced degrees in counseling, psychology, social work and/or marriage and family therapy. These staff are supervised by licensed or certified staff of Catalyst and by staff from their educational institution. I understand the credentials and qualifications of the staff person providing my services and give my consent for assessment, therapy, and other sessions with the staff from the Behavioral Health Department. I understand that "telehealth" includes assessment, evaluation, treatment transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. This also may include, but not limited to: Apple FaceTime, Facebook Messenger Video Chat, Google Hangouts Video, Skype, Doxy.me and /or telephonic means of communication. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually.

I understand that the services provided are therapeutic in nature to deal with emotional and behavioral issues. While in therapy there I a risk that symptoms may increase as these issues are dealt with. The client will have a treatment plan that is created with their participation as well as the guardian's participation. This plan will be followed and reviewed throughout therapy. Therapies used during treatment may vary, and you have a right to request a change in the method provided. You also have a right to request a change of therapist, or agency at any time during you or your child's treatment. The client and family are responsible for following through on treatment goals, objectives and therapy techniques developed and agreed upon in session. No client will be discriminated against based on religion, race, sex, or disability. It is the client's responsibility to keep appointments and follow the treatment plan, or services may be terminated. Finally, I understand that information about my case will not be disclosed by staff from Catalyst,or to any other person or agency without my written consent except in the following circumstances: 1) the staff member has reason to believe that I pose danger to myself or others, 2) The staff member has reason to believe There is evidence of child abuse, spouse abuse, or other adult abuse but not limited to reporting child, elder, and dependent adult abuse/neglect; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding, or 3) records or information are subpoenaed under court order.

Patient Consent to the Use of Telemedicine for Behavioral Health Services:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize _____**Catalyst Health & Wellness**_____ to use telemedicine in the course of my diagnosis and treatment. (Agency Name)

Signature of Patient (or authorized person) _____

Date/Time _____.

If authorized signer, relationship to patient _____

Witness _____ Date/Time _____