Lighthouse Child & Family Services

## Telehealth Services Consent Form

**Client Number_____**

Lighthouse Child and Family Services Inc offers mental health services using telehealth video conferencing. LCFS's telehealth services use HIPAA compliant software, which allows direct audio and visual communication over individual computers. LCFS recognizes that telehealth video conferencing can be an effective model for many therapy situations; however, there are some circumstances that telehealth is not an appropriate therapeutic model. LCFS reserves the right to decide not to offer and/or to discontinue services via video conferencing.

The Telehealth Services Consent Form is in addition to LCFS's in-person release and consent forms.

**Please review the following, then *sign and date the bottom* of this form.**

I have received and understand the LCFS Telehealth Services description; and I agree to participate in services and/or consultations via telehealth video conferencing.

I agree to use a secure network; and to download the HIPAA compliant video conferencing software onto my computer in order to access telehealth services.

I understand that internet connectivity is beyond the control of the therapist, and that in the event of connectivity failure, the therapist will respond with the established protocol.

I understand that the therapist providing services will be in a private location and will be the only person accessing the information on the computer. (When necessary, a language interpreter may also be present.)

I understand and agree that I (we) will be in a private location and only the identified clients will be in the room accessing the information on the computer. (When necessary, a language interpreter may also be present.)

I understand and agree that my insurance provider will be billed by LCFS for the services provided using telehealth.

I understand and agree that if my insurance provider does not provide reimbursement for any or all of the telehealth services, that I will pay the remaining or the entirety of the fees.

I understand and agree that my therapist may make the determination to discontinue telehealth services if she or he determines that the mental health services via telehealth are no longer an effective model.

## Emergency Contact

_____, agrees to be available at _____

*Print Name of Identified Adult* *Phone Number*

for emergency contact to provide a safety net; and will be contacted as deemed necessary by the therapist if the client poses a safety risk.

_____ _____

Client Signature Date

_____ _____

Parent Signature Date