Client Rights and Responsibilities for Participation in Telehealth Services

Prior to starting video-conferencing services, we discussed and agreed to the following:

- Confidentiality still applies to telehealth services, and the session will not be recorded without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it.
- You will need to use a computer with a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phones, other devices, and other people) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify your provider in advance (see Cancellations/No Show policy).
- You must provide a phone number where you can be reached in the event of technical problems, wherein the session needs to be restarted or rescheduled.
- You should confirm with your insurance company that telehealth sessions will be covered or reimbursed. If they are not covered, you are responsible for the full payment.

What you can expect:

- Your provider is utilizing the HIPAA compliant telehealth platform, Valant IO.
- Clients will need to register for an online client portal account through Valant.
- Once the provider has initiated the session the client will see a yellow banner on their portal account page which, when clicked, will launch the session. If the client logs into their account prior to the provider starting the session, they will have the option to do a self-check-in.
- If the client attempts to log in more than 15 minutes prior to the scheduled appointment time, the self-check-in button will not be available.

Informed Consent for Telehealth Services

I, _____ (Client/Guardian), hereby give my consent to **Jessica Grossnicklaus, PsyD, LLC** to provide _____ (Client) with live, interactive video telehealth services located at the following distant site location: **2001 Pine Lake Road, STE 200, Lincoln, NE 68512.**

I understand that:

- There are potential benefits and risks of telehealth video services (e.g., limits to client confidentiality) that differ from in-person services.
- I retain the right to refuse telehealth video services at any time without affecting my right to future treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- All existing confidentiality protections shall apply to my telehealth video services and I agree to receive an email with a link attached to join telehealth video sessions as appropriate.
- I shall have access to all medical information resulting from the telehealth communication, as provided by law.
- Information from the telehealth video services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
- If I decline telehealth video services for any reason (e.g., technical difficulties), I will work with my provider to find alternative treatment options, including telephone sessions or in-person services on a case-by-case basis.
- I will be informed if additional people beyond my provider will be present during my telehealth session.
- I will be informed if telehealth sessions will be recorded.
- I retain the right to exclude anyone from either the originating or distant site.
- I am required to provide an emergency contact and will work with my provider to identify the closest emergency room to my location, in the event of a crisis situation.
- My provider may determine that due to certain circumstances, telehealth video services are no longer appropriate and that we should resume our services in-person or through other alternative options.
- This consent is valid for six months for follow-up telehealth video services with this health care provider.

I have read **this document** and the **Patient Rights and Responsibilities for Participation in Telehealth Services** document carefully and my questions have been answered to my satisfaction.

_____ _____

Client Name (Print) **DOB**

_____ _____

Client/Guardian Signature **Date**

_____

Emergency Contact **Relationship to Client** **Phone Number**

_____

Email Address (where link to sessions can be sent) **Phone Number (if problems occur)**