University of Colorado Colorado Springs

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UCCS AGING CENTER ADDENDUM TO CONSENT FOR TREATMENT

Consent To Telehealth Service

I, _____, consent to participate in therapy/assessment sessions and communications via phone and/or video-conferencing using the HIPAA-compliant technology platform (as agreed with my therapist or provider) for Telehealth service. I will have the option to stop using Telehealth at any time by discussing with my therapist or provider about other ways of receiving care and treatment. Before I sign this Consent Form, I will have the opportunity to ask questions about Telehealth and the following:

I understand/agree that –

1. There are potential risks and benefits of using Telehealth service and there is no guarantee for information discussed to be totally secure or confidential when using technological device and internet-based platforms even when the best effort has been made to have it as secure as possible.

2. All confidentiality protections required by law and state regulation will apply for my care as explained in the Client Rights and Consent to Treatment form which I have completed prior to this arrangement for Telehealth service.

3. There will be No recording of any session unless permission is obtained from all parties involved; in the same way, no other persons should be present during the session unless invited or discussed prior to the start of a session; uninvited person(s) will be asked to leave the room/space before resuming session.

4. At the beginning of every Telehealth session, I will confirm that I am at the location we agreed upon and the phone number (or alternative phone no.) that I can be contactable. This is important in case the technological device or internet-based platform malfunctions; if a phone call is dropped, efforts will be made to reconnect, but if this cannot be done within 15 minutes, the session will be rescheduled.

5. I will use a secure internet connection and not public or free Wi-Fi.
    a. If using phone internet, I will ensure that my data plan is enough for Telehealth work or I will use a password protected Wi-Fi connection.
    b. I will consider wearing headphones rather than using a speaker especially when there is someone else in my home/space.
    c. I will inform my therapist or provider if someone enters my room/space to protect privacy.

6. Before starting any Telehealth service, a safety plan will be in place and it will include one emergency contact and the closest emergency room (ER) location in case there is a crisis situation; my therapist or provider may call my designated emergency contact before treatment or before a session to verify the contact's availability; in case of a crisis or emergency situation, I will dial 911 or the local crisis line 719-635-7000 for help, or go to the closest ER/hospital.

Emergency Contact Person: _____

Phone Number: _____ Relationship: _____

Hospital Name/Location: _____

7. I will need to be in a quiet, private space that is free of distractions and not at any public space or in a car driving; service will be provided like an in-office session and cell phones must be turned off or on silent-mode. I will also do my best to optimize lighting, camera angle, and volume of speech.

8. With the exception of scheduling or rescheduling appointments via phone, I will not use social media, video conference, instant messaging, or emails to contact my therapist or provider outside of our agreed upon appointments.

9. Telehealth is not suitable for everyone and if I or my therapist or provider determines that Telehealth is no longer beneficial or appropriate for me, we will discuss other options, including a referral to other providers outside of the Aging Center.

10. Similar to in-person services, Telehealth services have been assigned specific fees that I have been informed per the Aging Center's billing policy, and I agree that I am responsible for the full payment of the service rendered. If I am covered by any insurance policy, I am responsible for any payment not reimbursed by the insurance company.

11. It is important to be on time for any appointment scheduled. For cancellation or change of appointment, I will provide at least 24-hour notice to my therapist (for therapy) or at least 72-hour notice to my provider (for assessment); otherwise, a no-show fee may apply (as stipulated and informed under the billing policy); appointments will be scheduled/re-scheduled via phone.

I have read the preceding information and have also been given a verbal explanation. I hereby consent to receiving consultation, evaluation, and/or treatment via Telehealth.

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date

_____ _____

Supervisor Signature Date