Informed Consent Tele-health

Lincoln Pastoral Counseling Services ("LPCS")

Definition of Tele-health: Tele-health involves the use of electronic communications to enable mental health providers to connect with individuals using live interactive video and audio communications. Tele-health includes the practice of mental health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the following rights with respect to tele-health:

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to tele-health. This consent is an addendum to the standard informed consent you, the client, are required to sign at the beginning of counseling services. A copy of your previously signed Informed Consent can be provided. No sessions will be recorded without the permission of the client or the counselor at any time.

2. I understand that I have the right to withhold or withdraw my consent to the use of tele-health during my care at any time, without affecting my right to future care or treatment. Also, my mental health counselor can determine at any time that due to certain circumstances tele-health is no longer appropriate and we shall resume our sessions in person.

3. I understand that there are risks and consequences from tele-health, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

4. I understand that I am responsible to communicate through a computer that I know is safe i.e. wherein confidentiality can be ensured. I understand it is important to use a secure internet connection rather than a public/free Wi-Fi. I understand my responsibility to determine who has access to my computer and electronic information from my location. This would include family members, co-workers, supervisors and friends and whether or not confidentiality from your work or personal computer may be compromised. I understand that it is my responsibility to fully exit all online counseling sessions from my computer at the conclusion of each session.

5. I understand that it is my responsibility to ensure the privacy and confidentiality of my space without distractions while utilizing tele-health. I agree to show my mental health counselor this space at the beginning of each session to ensure confidentiality. I also agree to utilize ear/headphones during our sessions, when possible. I understand that all tele-health sessions will be provided by my LPCS therapist from the privacy of an office. LPCS utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver tele-health.

6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an

emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

Payment for Tele-health Services:
LPCS will bill insurance for tele-health services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles will apply and can be paid to LPCS through your therapist at the end of your session via credit card. If you are unable to pay via credit card, please promptly send a check to Lincoln Pastoral Counseling Services PO Box 441 Lincoln, IL 62656. In the event that insurance does not cover tele-health, or when there is no insurance coverage, you may wish to pay out-of-pocket based on the LPCS sliding scale rate. If you need to cancel or change your tele-health appointment, please notify 24 hours in advance by phone or email.

Patient Consent to the Use of Tele-health:
I have read and understand the information provided above regarding tele-health, have discussed it with my counselor, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of tele-health services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of tele-health services for treatment under the terms described herein.

By my electronic signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Client Printed Name:

Client Signature Date:

Client Signature: