
Informed Consent for Telehealth

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she/they is/are located at a different site than the provider; and hereby consent to my provider at South Shore Child and Family Counseling providing mental health care services via telehealth.

I understand that the laws that protect my privacy and the confidentiality of medical information also apply to telehealth. As always, your insurance carrier will have access to your medical records for billing, quality review, and audit.

I understand that I will need to contact my insurance company to verify that telehealth services are covered and I am eligible to receive such services. I also understand that I will be responsible for any copays, coinsurance, deductibles or charges that apply to my telehealth visit.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting staff at South Shore Child and Family Counseling. As long as this consent is in force and has not been revoked South Shore Child and Family Counseling may provide health care services to me via telehealth without the need for me to sign another consent form.

Client Name: _____ Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____

Client/Guardian Email Address: _____

Witness Signature: _____ Date: _____