KNOX COUNTY COMMUNITY Health Center
KNOX PUBLIC HEALTH

Informed Consent for Telehealth Services

Medical / Dental / Behavioral Health

I, _____, consent to engaging in telehealth services with the Knox County Community Health Center (KCCHC) as a part of the medical, dental or behavioral health services' offerings. I understand that telehealth services may include evaluation, assessment, consultation and/or treatment planning, and therapy. It has been explained how telehealth will be used and that is not the same as a direct patient / healthcare provider visit. Telehealth will occur primarily through telephonic, interactive audio and/or video communications.

By signing this consent, I am verifying that I understand the following:

1. I have the right to withhold or remove consent for telehealth service at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.
2. The state and federal laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that the visit is transmitted over dedicated lines and cannot be accessed by any unauthorized individuals.
3. I give my consent to be interviewed by the consulting healthcare provider. I also understand that other individuals may be present to operate the video equipment and that they will be held to the same standard of confidentiality for any/all information obtained.
4. 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 go to the nearest hospital or crisis facility. By signing this document, I acknowledge that I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.
5. I understand that a limited examination may take place during the telephonic or video conference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting healthcare provider.
6. I understand that there may be technological issues such as interruptions or difficulties which may occur. Due to this, my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the audio / video tele-conferencing connections are not adequate for the situation.
7. I understand that billing will occur from the healthcare provider and facility based on the telehealth services provided.

I have read this document and understand the risk and benefits of telehealth services and have had my questions regarding the services explained. I hereby consent to participate in a telehealth visit under the conditions described in this document.

Print Patient Name: _____ **DOB: _____**

Patient Signature: _____ **Date: _____**

Parent / Guardian Signature (if under 18): _____ **Date: _____**

Office Use Only:
In lieu of the required written consent or beneficiary signatures, verbal permission was requested and received prior to initiating the telehealth visit having covered all the items in the Informed Consent.
Verbal consent given by: _____Date:_____
Employee Name: _____Date:_____

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