lakes center
FOR YOUTH & FAMILIES

We are Lakes Center for Youth & Families.
Re-imagining to connect with you. Learn more: www.LC4YF.org

Re-imagining our possibilities supporting our residents of Columbus, East Bethel, Forest Lake, Ham Lake, Hugo, Lino Lakes, Marine, May, Scandia, Stacy, Wyoming, Chisago City, Lindstrom, Taylors Falls, Shafer, Rush City, Harris, Center City, and North Branch.

Telehealth Consent Form

Contact us via email at receptionist@lc4yf.org

1. I authorize Lakes Center for Youth & Families to allow me/the client to participate in a telehealth (videoconferencing) service.
2. The type of service to be provided by telehealth is counseling/behavioral health services/intervention services.
3. I understand that this service is not the same as a direct client/healthcare provider visit, because I/the client will not be in the same room as the healthcare provider performing the service.
4. My/the client's provider has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The attendant risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the client's healthcare provider or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.
6. I understand that the telehealth session will not be audio or video recorded at any time.
7. I agree to permit my/the client's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the client's healthcare provider to be present during my/the client's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:
   a. Omission of specific details of my/the client's medical history/physical examination that are personally sensitive, or
   b. Termination of the service at any time.
9. When the telehealth service is being used during an emergency, I understand that it is the responsibility of the telehealth provider to advise my/the client's local healthcare provider regarding necessary care and treatment.
10. It is the responsibility of the telehealth provider to conclude the service upon termination of the videoconference connection.
11. My/the client's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
12. I/the client agree that there have been no guarantees or assurances made about the results of this service.
13. I/the client acknowledge the telehealth program's no-show policy which states that I/the client will be discharged from the telehealth program if I/the client no-show for two (2) consecutive telehealth appointments, without prior contact to the scheduling staff.
14. **For Counseling Clients Only:** I/the client understand(s) that my/the client's insurance will be billed by Lakes Center for Youth & Families for telehealth counseling services if applicable. I/the client understand(s) that if my insurance does not cover telehealth services, I/the client may be billed directly for the provision of telehealth counseling services. I/the client understand(s) that I/the client are responsible for paying regular fees for telehealth intervention services.
15. I confirm that I have read and fully understand both the above and the Telehealth: What to Expect form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Client Signature	Print Name	Date
Parent/Guardian Signature (if applicable)	Print Name	Date

Relationship to Client (if applicable) _____

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the client/parent/guardian fully understands what I have explained and answered.

Provider's Signature	Date