**LUCY DANIELS CENTER CONSENT FOR TELEHEALTH CONSULTATION**

1.    I understand that my clinician is offering to provide mental health services to me or my child via telehealth.

2.    My clinician explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I/my child will not be in the same room as my provider.

3.    I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4.    I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my clinician or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5.    I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

**CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE**

By signing this form, I certify:

·       That I have read or had this form read and/or had this form explained to me. I understand that Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

·       That I fully understand its contents including the risks and benefits of the procedure(s).

·       That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I understand that my consent needs to be updated annually.

Client/Guardian signature

Date