Lamb Behavioral Health Center, LLC
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CONSENT ADDENDUM FOR TELEHEALTH SERVICES

Patient Name: _____ Date of Birth: _____

Telehealth service is the use of electronic and telecommunications technologies to support and promote long-distance health care services. LBHC is providing live (synchronous) videoconferencing, which is a two-way audiovisual link between the patient and the provider.

By signing this document, I acknowledge:

1. My health care provider is offering me the opportunity to engage in telehealth services.
2. I understand I will utilize a secure internet connection (i.e., not public Wi-Fi) and a device with a camera and microphone to access this technology.
3. I understand the importance of being in a quiet, private space that is free of distractions (including cell phone notifications) during the session.
4. I understand that video conferencing technology will not be the same as an in-person appointment.
5. I understand that a telehealth appointment has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
6. I understand there are potential risks to this technology, including interruptions, unauthorized access leading to loss of confidentiality, and technical difficulties.
7. I understand that the regular rights and limits of confidentiality still apply for telehealth appointments, and no one will record the session without permission of the other party.
8. I understand that I must check in on time to my scheduled appointment. The regular LBHC procedures for confirming, cancelling, and rescheduling an appointment will apply to telehealth appointments.
9. I understand there may be fees associated with this appointment, depending on whether or not I have insurance benefits that cover this service. Any fees must be paid before the appointment begins. LBHC attempts to receive accurate benefit details from insurance companies, but I am ultimately responsible for payment for this service if my insurance claims are denied.
10. I understand that my health care provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation.
11. I understand that my provider may determine that telehealth services are no longer appropriate for my care and may require me to schedule in-person appointments.
12. I have had opportunity to ask questions in regard to this format to providing services. 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.

In case of technical difficulties during my telehealth session, I can be reached at the following phone number to restart or reschedule my appointment:

Phone number: _____

CONSENT TO USE TELEHEALTH SERVICES VIA DOXY.ME

Doxy.me is the technology service LBHC will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Doxy.me is not an emergency service and in the event of an emergency, I will use a phone to call 911.
2. Doxy.me does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. My provider does not have access to all of the technical information for Doxy.me.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

SAFETY PLAN

In the event of a crisis situation during my telehealth appointment, I provide this emergency contact information and authorize my provider to contact them if necessary for my well-being.

Emergency contact name, relationship, phone number: _____

_____

During my appointment, the closest ER location/phone number to me is: _____

_____

By signing this form, I certify that I understand and agree to the information provided.

_____	_____	_____
Patient Signature, or Parent/Guardian Signature	Printed Name	Date
_____	_____	_____
Signature of Minor Patient	Printed Name	Date
_____	_____	_____
Signature, person explaining services	Position	Date

For additional questions, contact Lamb Behavioral Health Center, LLC at 979-436-1956.