Telehealth Informed Consent

1. Purpose and Benefits.

Telehealth is online or virtual counseling. As a part of telehealth sessions, you will be able to access our services while you are at home via a HIPAA compliant video platform and will exchange protected health information. The information that is exchanged may be used for diagnosis, counseling, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video

We will provide telehealth services using Zoom Video Conferencing for Telehealth. The telehealth consultation will be similar to group and individual sessions at office, except interactive video technology will allow you to communicate with counselors and therapist at a distance. At first you may find it difficult or uncomfortable to communicate using online video-setting. Our staff will assist you to be able to access our telehealth services as smooth as possible.

2. Potential Risks and Service Limitations:
   - Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
   - In rare events, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth session or a referral to a local psychologist or counselor as applicable.
   - In very rare events, security protocols could fail, causing a breach of privacy of personal health information.
   - Our providers do not address urgent cases or medical emergencies. If you believe you are experiencing a medical emergency, you should dial 911 and/or go to the nearest urgent care center or emergency room. After receiving urgent healthcare treatment, you should visit your primary care doctor.

3. Client's Responsibilities
   - Understand your individual & group session schedule and attend all scheduled sessions punctually. Inform counselor about your absence PRIOR to the session.
   - Use secure internet source and devise with private setting.
   - Do NOT share meeting information/password outside of group members.
   - Do not discuss group issues outside of groups sessions.

4. Client's Rights.

You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right of future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with your counselor in person if you travel to his or her location.

5. Consents
    - I hereby consent to receiving Cycles of Change Recovery Services' services via telehealth technologies. I understand that Cycles of Change Recovery Services and its providers offer telehealth-based substance abuse related educational/counseling/psychotherapy services, but that these services do not replace the relationship between me and my primary care doctor. I also understand it is up to the Cycles of Change Recovery Services provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.
    - I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Cycles of Change Recovery Services will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal health/mental related information to other health practitioners who may be located in other areas.
    - I understand that the importance to comply with Cycles of Change Recovery Services' Group Confidentiality Policies and make the best effort to comply to the policy. I further understand that group confidentiality in telehealth sessions rely on the group members dignity and compliance as well.
    - I understand there is a risk of technical failures during the telehealth encounter beyond the control of Cycles of Change Recovery Services. I agree to hold harmless Cycles of Change Recovery Services for delays in evaluation or for information lost due to such technical failures.
    - 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 understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.
    - I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Cycles of Change Recovery Services providers are not able to connect me directly to any local emergency services.
    - I understand that alternatives to telehealth consultation, such as in-person services, are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving tests or assessments may be conducted by individuals at my location, or at a testing facility, at the direction of the Cycles of Change Recovery Services provider.
    - I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
    - I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the session other than the Cycles of Change Recovery Services provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my

psychological health history that are personally sensitive to me; (2) ask unauthorized personnel to leave the telehealth session; and/or (3) terminate the session at any time.

- I understand that Cycles of Change Recovery Services does not provide psychiatric health care and that I will not be given a prescription at all. I understand that if I participate in a session, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

I have read this document carefully, and understand the risks and benefits of the telehealth session and have had my questions regarding the session explained and I hereby give my informed consent to participate in a telehealth session under the terms described herein.

By signing this "**INFORMED CONSENT FOR TELEHEALTH SERVICES**" I hereby state that I have read, understood, and agree to the terms of this document.

Patient Name:_____

Signature:_____ Date:_____