ASSOCIATED
COUNSELING
GROUP
♦ 748 N MAIN STREET ♦ FREMONT, NE 68025 ♦
♦ 402-941-7016 ♦

I, _____, agree to receive medically necessary live, interact video telehealth services from _____ who is located at a distant site location, for _____. This distant site location is located at _____.

I, _____, understand that:

a. I retain the right to refuse telehealth consultations at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

b. All existing confidentiality protections shall apply to my telehealth consultation.

c. I shall have access to all medical information resulting from the telehealth consultation, as provided by law.
d. Information from the telehealth services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
e. If I decline telehealth services, other alternative options are available to me, including in-person services. These options are: _____.
f. I will be informed wither the telehealth consultation will be or will not be recorded.
g. I will be informed of all people who will be present at all sites during my telehealth service.
h. I retain the right to exclude anyone from either the originating or distant site.
i. I understand that this consent is valid for six months for follow-up telehealth services with this health care provider.

I have read this document carefully and my questions have been answered to my satisfaction,

_____ Date : _____
Client Signature

_____ Date: _____
Parent/Guardian Signature

_____ Date: _____
Associated Counseling Group Practitioner Obtaining Consent

_____
Heath Care Facility Name Address Telephone