# *Big Sky Family Therapy*

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*Family Systems Trauma Therapy*
*Advanced Certificate*

*DIR/Floortime*
*Advanced Certificate*

## Tele-Behavioral Health Consent to Participate

**Client Name:**

1. I understand that my counselor wishes me to engage in a tele-behavioral health ("tele-health") consultation.
2. My counselor has explained to me how video conferencing technology will affect my session; it will not be the same as a direct patient/ counselor visit due to the fact that I will not be in the same room as my counselor.
3. I understand there are potential risks to using this technology, including interruptions, unauthorized access and technical difficulties. I understand that my counselor or I can discontinue the telehealth session if I feel that videoconferencing is not adequate for the situation.
4. I understand that my private healthcare information (PHI) may be shared for scheduling and billing purposes, as it is when I come into the Big Sky Family Therapy office for sessions.
5. I have had the alternatives to a telehealth visit explained to me, and I choose to participate.
6. I understand that billing will occur for this telehealth visit.
7. I have had the opportunity to ask questions in regard to this visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me;
- That I fully understand its contents including the risks and benefits of the use of telehealth visits;
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client/Parent/Guardian SIGNATURE

Date

Time (hr:min)