UNITY HEALING CENTER CONSENT FOR TELEHEALTH SERVICES

Health care services are available by two-way interactive video communications. Referred to as "telehealth", this means that I may participate with a behavioral health care provider and/or family member(s) from a different location. Since this is different than the type of therapeutic intervention with which I am familiar, I understand and agree to the following:

1. The behavioral health care provider and/or family member(s) will be at a different location from me. Unity Healing Center (UHC) staff will be at my location with me to assist in the consultation.
2. UHC will utilize IHS HIPAA approved systems for telehealth video sessions.
3. The behavioral health provider will have access to medical information, details of treatment progress, and other pertinent treatment information that support continuum of care.
4. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the behavioral health care provider or family members.
5. Video recordings may be taken of the telehealth consultation, after I have given my written permission prior to recording. Video recordings and photos may be kept, viewed, and used for purposes including teaching, training or administrative purposes.
6. The behavioral health care provider will record the pertinent information in the respective medical record directly or by electronic transmittal (fax/secure mail) which shall be maintained at Unity Healing Center.
7. This type of telehealth services has the following risks including, but not limited to:
   a. increased risk of disclosure of personal health information,
   b. potential technology failures (such as loss of video or sound which may result in rescheduled session),
   c. inherent confidentiality risks of electronic communication.
8. This consent is voluntary and constitutes a waiver of the usual right to counselor-resident privacy.
9. The assigned UHC on-site counselor/Clinic Supervisor will be notified of immediate needs and will consult with telehealth provider as needed. Routine staffing with UHC on-site staff will be provided to ensure continuum of care.

I further understand that I have the right to:

1. Refuse the telehealth consultation, or stop my participation in the telehealth consultation at any time.
2. Request that all personnel leave the room(s) to allow a private consultation with the off-site behavioral health care provider or family member(s).

I acknowledge I have been explained and any question answered regarding the telehealth services (video). Understanding the above, I consent to the telehealth process described above.

Parent/Guardian Signature: _____ Date: _____

Resident Signature: _____ Date: _____