Supported Employment and Psych Rehabilitation
Telehealth Services Informed Consent

This form describes GIC STEP's telehealth service agreement and includes:

- Your consent to receive behavioral health services from GIC STEP;
- Your agreement to receive services using telehealth technology; and/or
- Your agreement to opt out of receiving services using telehealth technology.

By signing my name on this document, I understand and agree that I am signing this Consent and that I have reviewed, understand and accept the risks and benefits of telehealth services as described below and wish to receive such services.

1. By signing the telehealth agreement, I agree to receive telehealth services. Telehealth involves the delivery of behavioral health services, including assessment, treatment, and education, using interactive audio, video, and data communications. During my visit, my GIC STEP provider and I will be able to see and/or speak with each other from remote locations.

2. I consent to, understand and agree that:

- I will not be in the same location or room as my behavioral health provider.
- My behavioral health provider meets all of the qualifications in the state in which I am receiving services. I will report my location accurately during registration.
- Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to behavioral health care if I am unable to travel to my GIC provider's office; (ii) more efficient behavioral health evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, staff and other individuals at a community based location.
- Potential risks of telehealth include: (i) delays in assessment and services due to technical difficulties or interruptions, unauthorized access to my information, or loss of information due to technical failures. I will not hold GIC responsible for lost information due to technological failures.
- My GIC provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my GIC provider relies on information provided by me before and during our telehealth encounter and that I must provide information about my behavioral health history, condition(s), and current or previous behavioral health care that is complete and accurate to the best of my ability.
- I may discuss these risks and benefits with my GIC provider and will be given an opportunity to ask questions about telehealth services. I have the right to withdraw this consent to telehealth services or end the telehealth session at any time without affecting my right to future services from GIC.
- The level of care provided by my GIC provider is to be the same level of care that is available to me through an in-person visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest behavioral health center, hospital emergency department or other appropriate health care provider.
- My GIC provider will not record my video and/or audio nor take photographs during my telehealth sessions.
- In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.
- The laws of the state in which I am located will apply to my receipt of telehealth services
- I confirm the environment of my remote site is accessible, private, and has functional equipment to engage in telehealth services.
- The option to engage in telehealth services can be revoked by either party, service provider or program Participant, if considerations of quality of care, non-compliant with telehealth agreement or needs of service delivery were to change.

- In case of emergency during telehealth services, my provider will dial 911 and provide the above remote location.

- I confirm that I will be using the following device(s) to engage in telehealth services (check all that apply):

  _____ Telephone (Landline)
  _____ Cell Phone
  _____ Computer (Desktop or Laptop)
  _____ Tablet
  _____ Other: _____

- I confirm that I have the skills and abilities to operate the necessary technology and/or equipment to engage in telehealth services:

  _____ Yes

  _____ No

  If no, I can ask my service provider for assistance to learn how to operate the necessary technology and/or equipment to engage in telehealth services.

- I am choosing to:

  _____ Receive behavioral health services via telehealth.

  _____ Opt out of receiving telehealth services via telehealth.

_____	_____
Participant Name (Print)	**Staff Name (Print)**
_____	_____
Participant Signature	**Staff Signature**
_____	_____
Date	**Date**