BIA

BEHAVIORAL INSTITUTE OF ATLANTA LLC
Because Change is Possible at Any Age
6000 Lake Forrest Drive, Atlanta, GA 30328 (404) 256-9325

CONSENT FOR TELEHEALTH SERVICES

1. I understand that my provider is providing telehealth services which may include telephone or video conferencing.

2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

3. I understand that my provider will take measures to protect the confidentiality of our telehealth appointments. At the same time, there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

4. I understand that my provider or I can discontinue the telehealth appointment if it is felt that the telephone or video connections are not adequate for the situation.

5. I have had the opportunity to ask my provider questions about telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me so that I understand them.

6. I understand that telehealth is NOT an Emergency Service and in the event of an emergency, I will call 911 or other appropriate agency providing emergency services.

7. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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 procedure(s), and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I understand I can revoke this consent at any time by written request.

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Client name (printed)

______________________________________ __________________________

Client or Parent signature Date