ochealth CARE AGENCY

ORANGE COUNTY HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
INFORMED CONSENT FOR SERVICES

General Informed Consent for Telehealth and Telephonic Services

In accordance with existing law, the following has been explained to me: the nature and purpose of the proposed evaluation, the nature of psychotherapy, alternative therapies, and other treatment methods including the alternative of no treatment, and I understand the risks involved. I consent and authorize the following services necessary for my health and well-being:

1. Assessment
2. Counseling or Therapy
3. Group Education or Therapy (if applicable and deemed appropriate)
4. Medication Support
5. Case Management (e.g., referrals, linkage, consultations)
6. Monitored screening for substances and other drugs that affect my health and well-being

I understand that the above services may be rendered to me via telephone and/or telehealth, and as deemed appropriate by my provider where I am seeking services.

Telehealth involves the use of audio, video or other electronic communications to interact with me, consult with my healthcare provider and/or review my medical/behavioral health information for the purpose of diagnosis, therapy, follow-up and/or education. During my telehealth and/or telephone (telephonic) evaluation, details of my medical and behavioral health history and personal health information may be discussed with me and/or other health professionals through the use of interactive video, audio and telecommunications technology.

The potential risk of telehealth and telephonic services is that there could be a partial or complete failure of the equipment being used which could result in behavioral health staff's inability to complete the evaluation, behavioral health services, and/or prescription process. Another potential risk of telehealth and telephonic services could be that because of my specific behavioral health condition, or due to technical problems, a face-to-face consultation may still be necessary after the telehealth and/or telephonic appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of privacy. The alternative to telehealth and telephonic services would be a face-to-face or in-person appointment.

I have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand I have the option to request in-person services if I prefer.

I understand the following with regards to participating in telehealth and telephonic services:

- There is no permanent video or voice recording kept of telehealth and telephonic services sessions.
- All existing confidentiality protections under federal and California law apply to information used or disclosed during telehealth and telephonic services.
- I understand I have the right to all confidentiality protections whether services are delivered to me in person, via telephone, or telehealth.

- I understand I have a right to access and copies of all transmitted medical/mental health information.
- There shall be no dissemination of any images or information to other entities without further written consent and an Authorization to Disclose (ATD) Protected Health Information (PHI).
- I understand that I am fully responsible for any costs including overage charges on my phone and/or data plan associated with receiving telehealth and/or telephonic services.

I understand that acceptance and participation in telehealth and telephonic services is voluntary and shall not be considered a prerequisite for access to other community services.

If I am a Medi-Cal beneficiary (Orange MHP and/or DMC-ODS), I understand that I retain the right to request other Medi-Cal, Short Doyle/Medi-Cal or Specialty Mental Health reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

I may be contacted after my participation in the program has ended to evaluate my progress and condition. I understand that I may choose not to answer any questions at that time if I do not wish to do so.

I am satisfied that I have received all the information I need to make an informed decision about telehealth and telephonic services. The risks, benefits, and consequences of telehealth and telephonic services have been explained to me. I have had an opportunity to ask questions about this information and all of my questions have been answered. I certify that I have read, understand and agree with the above and will receive a copy of this consent form. In an emergency situation, I will be provided a copy of this consent as soon as is feasible, via mail, or in-person.

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Beneficiary / Participant Name

______________________________________ ______________________
Beneficiary / Participant Signature Date

______________________________________ ______________________
Responsible Party/Representative Name Relationship to Beneficiary

______________________________________ ______________________
Responsible Party/Representative Signature Date

______________________________________ ______________________
Provider / Witness Signature Date

______________________________________ ______________________
This form was translated to the Beneficiary/ Responsible Party by (Name) Translated Language