

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My healthcare provider explained to me how video conferencing technology will be used to affect such a consultation will not be the same as a direct client/health care provider visit because I will be in a different room than my provider.
3. 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.
4. I understand this technology's potential risks, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered, and the risks, benefits, and practical alternatives have been discussed with me in a language I understand.

CONSENT TO USE THE TELEHEALTH BY *KLM Counseling* OR ZOOM

Telehealth via Zoom is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use, and no passwords are required to log in. By signing this document, I acknowledge the following:

1. Telehealth by Zoom is NOT an Emergency Service, and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Neither Zoom nor the Telehealth Service provides any medical or healthcare services or advice, including emergency or urgent medical services.
3. Telehealth by Zoom Service facilitates videoconferencing and is not responsible for delivering any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information in Zoom – or that such information is current, accurate, or up-to-date. I will not rely on my healthcare provider to have this information in Zoom.
5. To maintain confidentiality, I will not share my telehealth appointment Zoom link with anyone unauthorized to attend the appointment.

By signing this form, I certify the following:

- That I have read or had this form read and had this form explained to me.
- That I fully understand its contents, including the procedure's risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client Signature:

Client Name:
