Sequoia Springs
TRAUMA HEALING CENTER

Informed Consent for Telepractice Services

Patient Name:_____

Date of Birth:_____

Telephone Number:_____

Address:_____

1. I understand there may be times when my Sequoia Springs provider wishes me to engage in telepractice treatment services. "Telepractice" means providing behavioral health services through interactive audio, video or electronic communication that occurs between the behavioral health professional and the client, including any electronic communication for evaluation, diagnosis and treatment, including distance counseling, in a secure platform, and that meets the requirements of telemedicine.
2. My Sequoia Springs provider has explained to me how and why telepractice services may be used.
3. I understand there are potential risks to this technology including interruptions, unauthorized access and technical difficulties. I understand my provider or I can discontinue the telepractice visit if it is felt that the connection is not adequate for the situation.
4. In an emergent situation, I understand that the responsibility of the Sequoia Springs provider is to secure emergency services and my Sequoia Springs provider's responsibility ends when crisis services arrive.
    a. In cases where electronic communication does not involve video, the clinician will identify the client by using voice recognition to ensure confidentiality.
    b. Emergency procedures when the clinician is unavailable will be the same as previously stated in the Informed Consent Agreement that you signed at the beginning of treatment- *True emergencies should be directed to emergency medical services or to the local crisis response center.*
5. I understand that payment does not change when telepractice options are utilized.
6. I have had a direct conversation with my provider about the risks and benefits related to the utilization of a temporary telepractice option and had the opportunity to ask questions regarding this option. I acknowledge my questions have been answered by my provider.
7. I have the option of revoking this consent at any time temporary telepractice services are no longer needed or beneficial.

By signing this form, I certify:

- That I have read or had this form read and explained to me
- That I fully understand its contents including the risks and benefits of temporary telepractice options
- That I have been given ample opportunity to ask questions and those questions have been answered.

_____ _____
Patient/Guardian Signature Date

_____ _____
Sequoia Springs Provider Signature Date

ROI for Telepractice Emergency Contact

Name of Emergency Contact:_____

Telephone Number of Emergency Contact:_____

***I consent to Sequoia Springs provider(s) to contacting my emergency contact in the event of a medical or behavioral health emergency that occurs during a telepractice session _____ (initial here)**