North Central Health Care

Person centered. Outcome focused.

INFORMED CONSENT FOR SERVICES

Name:_____ **DOB:**_____ **MRN:**_____

Consent Date**:**_____ Expiration Date:_____

- Telehealth Services
- In Person Services

I understand that by signing this agreement, I consent to all General care and/or routine services, including evaluation, therapies, nursing care, diagnostic testing, mental health and drug and alcohol treatment provided under the general or specific instruction of the health care provider(s).

Telehealth: I also understand that by consenting to engage in telehealth services through North Central health Care by audio/visual conference. I understand that "telehealth" includes the practice of health care delivery, diagnostic, consultations, treatment, transfer of medical data and education using interactive audio, video, or date communications. I am also acknowledging that I am aware of the following:

I understand that there are risks and consequences from telehealth including, but not limited to, the possibility despite reasonable efforts on the part of the psychiatrist/therapist that:

a) The transmission of my medical information could be disrupted or distorted by technical failures.
b) The transmission of my medical information could be accessed by unauthorized persons.
c) I also understand that if my service provider believes I would be better serviced by another form of service I will be referred to another provider.

In Person: I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction of supervision of my physician(s) or other authorized health care providers.

The laws that protect the confidentiality of my medical information apply to not only in person services but also for telehealth services. I understand that if I am receiving telehealth services, that the results cannot be guaranteed or assured.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment, or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

This consent to treat will expire 15 months from the date of signature. I have read and understand the above and have had an opportunity to ask questions about his information, and I consent to the evaluation and treatment and understand that special consent form may be needed for other specific procedures.

_____ _____

Signature – Patient/Client *Date/Time Signed*

_____ _____ _____

Signature – Parent/Guardian/Other *Relationship* *Date/Time Signed*