Family Solutions Services, Inc.

Orange City Office: 712-707-9222
1217 Hwy 10 W., PO Box 258

Cherokee Office: 712-707-9222
795 N. 2nd St.

Le Mars Office: 712-707-9222
19 2nd Ave. NW

Sioux City Office: 712-258-4553
2910 Hamilton Blvd. Lower A

1. **PURPOSE:** The purpose of this form is to obtain your consent for a telemental health with your BHIS/CMH/THERAPIST from Family Solutions Services, Inc. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or electronic means between a practitioner and a client who are located in two different locations.
2. I understand I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
3. I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
4. I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that a higher level of care is required. I understand that my practitioner may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
6. All laws concerning patient access to medical records and copies of medical records apply to telemental health.
7. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session.

You may withdraw your consent at any time.

Verbal consent given to provide telemental health services for:___________________________
(Client Name)

on Date:_____________________ Verbal consent given by:___________________________
(Client/Parent/Guardian)

Signature of Practioner:____

Signature of Client/Parent/Guardian:____