Nebraska Telehealth Patient Consent Form

I (name) _____ agree to this health care service, mental health including but not limited to intake sessions and therapy, as a Telehealth service. I understand that the health care practitioner is Dr. Shelly R. Benshoof located at Behavioral Health Solutions, PC 917 Wildwood Lane, Nebraska City, NE.

A Telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up Telehealth services with the health care provider.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the Telehealth service.
- If I decline the Telehealth services, the other options/alternatives available for me, including in-person services or another provider.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- I may exclude anyone from any site during my Telehealth service.
- I may see an appropriately trained staff person or employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
- I also understand that my insurance will be billed for this visit with consulting health care provider, Dr. Shelly R. Benshoof , and that I may be billed for what my insurance does not cover, dependent upon the provider. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.
- I give permission for the Behavioral Health Solutions to provide limited information to the coordinator at this site for billing purposes.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for 6 months and will be renewed after that time.

_____ _____

Name of Patient Date

_____ _____

Signature of Parent or Legal Representative Date

_____ _____

If other than patient, relationship to patient Reason (minor, incompetent, etc.)

_____ _____

Witness Date

Telehealth Consent:

_____ _____

Signature of Person Obtaining Consent Date

Facility: Behavioral Health Solutions, PC 917 Wildwood Lane, Ste 153, Wildwood Lane, Nebraska City, NE 68410

☐ Copy given to patient