1530 S 70th Street, Suite 200
Lincoln, Nebraska 68506
Phone: 402.327.0073
Fax: 402.327.0204

Telehealth Consent

_________________________________ hereby consents to participate in live, interactive telehealth or telemedicine services with the following provider(s) ☐ Tim Riley, PhD, ☐ Aaron Stratman, PhD, ☐ Julie Maikranz, PhD, ☐ Kara Antoniak, APRN, ☐ Susan Gripp, APRN for psychotherapy and/or psychiatry services. I understand that during any telehealth or telemedicine session the provider(s) will be located in a secure and confidential setting at either the MidWest Behavioral Health offices at 1530 South 70th Street, Suite 200 in Lincoln, Nebraska or at their respective private residences. I understand that the terms 'telehealth' or 'telemedicine' as used here include diagnosis, consultation, treatment, conveyance of medical information, and education utilizing audio, video or data communication.

I agree to participate in these services using the recommended video-conferencing platform and understand that my provider or their representative will instruct me in its use. I understand that I will be required to provide my own smartphone, tablet, or computer with both video and audio capability and to arrange a quiet and private space with minimal distractions during our sessions. I understand and agree that I will connect only from a private internet connection at my home or other secure location and at no time utilize a public or free Wi-Fi connection for this purpose.

My provider or their representative will contact me at the phone number listed below to arrange for reconnecting, restarting or reconnecting any session interrupted by technical issues. I understand that my provider is not responsible for any technical issues that may arise. In addition, I will work with my provider to develop a safety plan during our first telehealth session to include at least one emergency contact (name and number) and the location of the emergency room nearest me to be implemented in the event of a crisis situation. If my provider or I determine that telehealth is no longer appropriate or required, we will resume in-person sessions as indicated.

I understand and acknowledge the following rights and limitations with respect to telehealth services:

1. I may refuse to participate in telehealth services at any time without in any way affecting my right to future care or treatment and any program benefits I would otherwise be entitled to will not be withdrawn or denied for this reason.
2. All applicable confidentiality protections related to me or my health records will apply to all telehealth sessions and no recordings of any part of any session will be made without my express written permission
3. There are potential risks associated with telehealth including, but not limited to, the possibility of disruption or distortion of sessions by technical problems or unauthorized access by third parties.
4. I retain the right of access to all medical information resulting from telehealth sessions as provided by law
5. No information of any kind resulting from these telehealth sessions will be released to any third party for any reason without my express written consent.

6. If I decline these services, other options including in-person services or transfer to alternate providers in the community will be available to me.
7. I will be advised of all persons who will be present at the provider site during my telehealth sessions.
8. I retain the right to exclude anyone from the provider site or my own site at my sole discretion.
9. Ordinary billing practices will be applied to these sessions including submitting of charges to my insurance provide and, potentially, charges to me for balances not covered by my insurance as allowed. I may consult at any time about billing questions with my provider's billing office at (402) 327-0073.
10. This consent is valid for a period of twelve (12) months from the date signed for follow up telehealth services with the identified provider(s). I may revoke this agreement in writing at any time.
11. I have had an opportunity to discuss any questions or concerns about these services with my provider(s) or their representative and have been offered or received a copy of this agreement.

______________________________ ______________________

Patient Name Contact Phone Number

______________________________ ______________________

Signature of Patient, Parent or Guardian Date

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Relationship to Patient (If Not Patient) Signature

______________________________ ______________________

Signature of Provider or Representative Date

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E-mail address for telehealth contact

Non-Secure Communications Agreement

Text messages or unsecured Email may be a preferred or requested method of communication between providers and patients. Because of the potential risks to confidentiality we require your consent before we use these methods. Direct voice contact by phone or secure Email will be our first option wherever possible. Please note that our mwnf-ne.com Email system is fully encrypted for both send and receive functions. If you are unsure about how to access this system, ask your provider or our front office staff.

Risks of Text Message or Unsecured Email Communication

Risks include, but are not limited to the following:

12. Text messages and Email records are considered as unencrypted and therefore subject to being intercepted, altered, forwarded or used by unauthorized third parties without permission or detection.
13. Text messages and Email records may be used as evidence in legal proceedings.
14. Even minor errors with cell phone numbers or email addresses may result in your private information being sent to unintended recipients.
15. Employers and online services have the right to inspect Emails sent through their electronic systems
16. Backup copies of text messages and Emails may still exist even after the sender and recipient delete the message from their devices
17. Text and Email messages may be stored physically or electronically and be circulated to unintended recipients.

Conditions and Limitations for Text and/or Email Communication

1. Emergency or urgent situations: Text or Email communication is never appropriate for emergency or urgent circumstances. Providers cannot guarantee they will be available to read or respond to such messages at any particular time.
2. Content: Text or Email communication should be concise. Patients or responsible parties should telephone or schedule an appointment to discuss more involved or sensitive issues.
3. Records: Providers may choose to print and maintain copies or any text or Email communication in patient charts.
4. Message Forwarding: Providers will in no case share or forward patient or responsible party text or Email communication without express written consent or as authorized by law.
5. Personal Private Information: Patients or responsible parties should not communicate any personal or sensitive information via text or unsecured Email.
6. Patient Responsibility: Providers assume no responsibility for the protection of unsolicited information or breaches of confidentiality initiated or caused by patients, responsible parties or outside third parties.

Patient Name	Mobile Phone Number
Email Address	Alternate Mobile Phone Number
Signature of Patient or Responsible Party	Date
Printed Name of Patient or Responsible Party	

☐ I **DO NOT** consent to the use of text messaging or non-secure Email

NOTE: Patient is responsible for supplying updated information in the event of any change