

New Orleans Charter Science & Mathematics High School  
LSUHSC School-Based Health Center  
5625 Loyola Ave., New Orleans, LA 70115  
Phone: 504-613-5648 / Fax: 504-866-4642

### **Virtual Behavioral Health Care Informed Consent Form**

Virtual Care involves the use of electronic communication to deliver clinical health care services between a practitioner and a client who are located in two different locations. The laws that protect privacy and confidentiality of medical information also apply to telehealth, so any consultation via virtual care is secure and confidential.

#### **Potential Risks:**

- Videoconferencing equipment could fail, causing delays in medical evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- There could be breaches of confidentiality by unauthorized persons.
- The patient could incur data or internet/wifi usage charges due to the use of electronic communication.
- The practitioner has limited ability to respond to emergencies.

#### **I Understand the Following Concerning Virtual Care:**

- It has been explained to me how videoconferencing technology will be used to facilitate care since the provider and I/ my child will not be in the same room.
- The alternatives to virtual care have been explained to me, and I have chosen for me/my child to participate in virtual care.
- I understand that virtual care should never be used for urgent matters. Therefore, for all urgent health care matters, I will go to or I will bring my child, without delay, to the emergency department of a local hospital, and/or dial 911.
- I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to virtual care unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others)
- I understand that I have the right to withhold or withdraw consent at any time without affecting my/ my child's right to future care, services, or programs for which I/my child may be eligible. • I understand that I may decline to receive virtual care and may withhold or withdraw my consent from such care at any time without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my provider. As long as this consent is in force (has not been revoked) my provider may provide virtual care services to me without the need for me to sign another consent form.
- I understand that 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.

- I understand that if I/ my child is 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 virtual care is not appropriate and a higher level of care is required.
- I understand that my provider may need to contact my/ my child's emergency contact and/or appropriate authorities in case of an emergency.
- I understand that during a virtual care session, technical difficulties could result in service interruptions. If this occurs, I will end and restart the session. If we are unable to reconnect within ten minutes, I will call 504-264-1994 (Social Work) or 504-484-9505 to discuss the connection and possibly reschedule.

**Emergency Protocols:**

Your provider needs to know your/ your child's location in case of an emergency. You agree to inform me of the address where you/ your child is at the beginning of each session. Your provider will also need a contact person who they may contact on your/ your child's behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you/ your child to the hospital in the event of an emergency.

I have read/ reviewed the information provided above and discussed it with my provider. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

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Name of Patient

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Signature of Patient/Legal Guardian

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Date