Chicagoland Cognitive Assessment Center, LLC
Telehealth Consent Form

I hereby consent to participate in Telehealth services provided by Chicagoland Cognitive Assessment Center, LLC.

I understand that Telehealth is the use of electronic communication methods to deliver psychological services remotely. This can include live videoconferencing, telephone conversations, and other forms of electronic communication.

I acknowledge and agree to the following terms and conditions:

1. **Purpose:** I understand that the purpose of Telehealth is to provide psychological services to me, including but not limited to assessment, diagnosis, consultation, and treatment.
2. **Potential Benefits and Risks:** I understand that Telehealth has potential benefits, such as increased accessibility to services and reduced need for travel. However, I also acknowledge that there may be risks, including but not limited to: technical difficulties, limitations in the assessment or treatment process, and possible breaches of confidentiality.
3. **Confidentiality:** I understand that the same confidentiality and privacy protections that apply to in-person psychological services also apply to Telehealth services. I acknowledge that my psychologist will take reasonable steps to protect my privacy and maintain the confidentiality of the information exchanged during Telehealth sessions.
4. **Security:** I understand that my psychologist will use secure, encrypted videoconferencing software and other communication tools compliant with the Health Insurance Portability and Accountability Act (HIPAA) to ensure the privacy and security of my Telehealth sessions.
5. **Emergency Situations:** I understand that in case of an emergency, my psychologist may need to contact local emergency services on my behalf. I provide my current address and phone number for emergency purposes at each visit.
6. **Technical Issues:** I understand that technical issues may arise during Telehealth sessions, such as connection problems or equipment failure. In the event of technical difficulties, I agree to contact my psychologist by phone or email to discuss alternative methods of communication or reschedule the session.
7. **Billing and Insurance:** I understand that Telehealth services may be billed and reimbursed differently than in-person services. I am responsible for understanding my insurance coverage and any associated costs for Telehealth services.
8. **Right to Withdraw Consent:** I understand that I have the right to withdraw my consent to participate in Telehealth services at any time without affecting my right to future care or treatment.

By signing this consent form, I confirm that I have read, understood, and agree to the terms and conditions outlined above. I voluntarily give my consent to participate in Telehealth services provided by my Behavioral Health Provider.

Patient's (or Guarantor if Patient is a Minor) Signature: _____

Date: _____