

1428 44th Street SW
Wyoming, MI 49509
P// 616.604.8492
F// 616.604.8493

854 Washington Ave Suite 600
Holland, MI 49423
P// 616.499.2218
F// 616.499.2219

185 44th Street SW Ste B
Grandville, MI 49418
P// 616.244.2246
F// 616.244.2247

Consent for Telehealth Services

This form is designed to allow you to give informed consent for the use of video technology for online therapy known as telehealth services. This is to be used in conjunction with, but does not replace, the informed consent document that is required of all clients prior to starting therapy services at Developmental Enhancement, PLC.

The benefits of telehealth services include the convenience of location, time, and accessibility which allows for better continuity of care during the time of the COVID-19 outbreak.

Telehealth services are defined as a clinical encounter using video technology. Developmental Enhancement, PLC will use Doxy.me, Skype for Business, Zoom, GoToMeeting, or any other HIPAA compliant platform that uses video conferencing technology to connect clinician providers and clients securely.

In the event of disruptions or connectivity issues preventing the session from occurring, the therapist will either use the in-session video chat to troubleshoot or will call you back in an attempt to reconnect and/or reschedule the session.

Please provide your primary contact number and, if applicable, an alternate number below:

Primary Contact Number

Secondary Contact Number

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

Consent for Treatment

I, the client/legal parent or guardian, understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that Developmental Enhancement, PLC, or I can discontinue telehealth service if we believe that the videoconferencing connections are not adequate for the situation. I understand that problems with internet availability or connectivity are outside the control of Developmental Enhancement, PLC and cannot be guaranteed.

I agree to take full responsibility for the security of any communications or treatment on my own computer and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission except where disclosure is required by law.

I understand that I am not allowed to record, take screenshots, etc. of any kind, of any session, and doing so would be grounds for termination of the client-therapist relationship.

I hereby give consent for staff at Developmental Enhancement, PLC, to provide telehealth services as considered necessary and advisable for me/my child and understand that I may withdraw consent for such care, treatment, or services that I receive at any time.

By signing this informed consent, I acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name

DOB

Client or Parent/Guardian Signature

Date

Please submit completed consent forms to info@debh.org