



**Oliver Behavioral Consultants, LLC**  
550 Thornton Parkway. #234 Thornton CO 80229  
**Office:** (720) 459-7493 Fax: (720) 583-2382

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## CONSENT FOR TELEHEALTH TREATMENT

I, \_\_\_\_\_ (parent/guardian printed name) do hereby give my authorization for Oliver Behavioral Consultants, LLC (OBC) to receive telehealth treatment for my child \_\_\_\_\_ . Please be aware of the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the therapist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Please check the box/boxes your consent to release:

Use to conduct therapy

Use to complete assessment

Use to communicate treatment issues



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I understand that my child's confidentiality will be maintained at all times and all personal information concerning my child will not be released or used in any way. I further understand that I may, at any time, change my mind and overturn this consent, without any questioning from OBC. I may also request copies of all video/audio recordings where my child is present.

Prior to treating the member through telemedicine for the first time, the provider must furnish each member with all of the following written statements, which must be signed (electronic signatures will be accepted) by the member or the member's legal representative:

- The member retains the option to refuse the delivery of health care services via telemedicine at any time without affecting the member's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the member would otherwise be entitled.
- All applicable confidentiality protections shall apply to the services.
- The members shall have access to all medical information resulting from the telemedicine services as provided by applicable law for member access to his or her medical records.  
[C. R. S. 2018, 25.5-5-320 (4)]

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date