Telehealth

Psychiatric/MH Treatment Consent

I have received, read and understand the information on informed consent for treatment contained in the brochure entitled *Your Rights As a Patient of the Marshfield Clinic Health System Department of Psychiatry and Behavioral Health*.

- I understand that the services I will receive will be provided via telehealth and that there is an increased risk for loss of security/privacy when using technology. I also acknowledge my right to receive services from a provider who can see me in person.

- I understand that I have the right to discuss the following topics with my mental health provider: The benefits of the proposed treatment and services; the way the treatment is to be administered and the services are to be provided; the expected treatment side effects or risks of side effects (including side effects or risks of side effects from medications); alternative treatment modalities and services; option of using telehealth; the probable consequences of not receiving the proposed treatment and services. This consent to treatment is effective for 12 months from the date of my signature.

- I understand that I may withdraw this consent at any time except to the extent that my providers have taken actions in reliance upon this consent.

- I understand that if I refuse to give this consent to treatment, I cannot be treated.

By my signature, I acknowledge that I have received an explanation and understand the information as stated above.

By my signature, I acknowledge that I have received an explanation and understand the information as stated above.

I have personally explained the above information to the patient or the patient's representative.

**Acknowledgement of Client’s Bill of Rights/Grievance Process/Treatment Costs**

I have received, read and understand the information contained in the brochure entitled *Your Rights As a Patient of the Marshfield Clinic Health System Department of Psychiatry and Behavioral Health* on the following matters pertaining to my care and treatment:

- The client’s Bill of Rights
- The grievance process and availability of client rights specialists
- The cost of care and treatment

Patient’s signature

Date (month/day/year)  Time

Patient’s legal representative signature is not required.

Patient’s legal representative signature  Relationship  Date (month/day/year)  Time