Consent for Telehealth Group Counseling Services

Please read this consent and the attached guidelines for telehealth group counseling services and sign below where indicated.

1. I understand that I will be participating in a telehealth group counseling session with a University of Nebraska Counseling and Psychological Services (CAPS) provider.

2. I attest that I am physically present in the State of Nebraska for the duration of the group sessions.

3. I understand that the benefits to a telehealth group sessions include having access to counseling services without having to travel to the CAPS.

4. I have had the alternatives to telehealth explained to me, and am choosing to participate in a telehealth group counseling.

5. My provider has explained to me how the video conferencing technology that will be used for group services and how this will not be the same as direct provider services due to the fact that I will not be in the same room as the provider.

6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

7. I understand that my provider or I can discontinue the telehealth group session if it is felt that the videoconferencing connections are not adequate for the situation.

8. I understand that my healthcare information will be maintained to the same privacy standards as an in-person session but may be shared with others for scheduling purposes.

9. I may withhold or withdraw my consent to the telehealth group counseling at any time without affecting my right to future care or treatment.

10. I will have a direct conversation with my provider, during which I will have the opportunity to ask questions in regard to this service.

11. My questions will be answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, you certify:

1. That you are physically present in the State of Nebraska.
2. That you have read or had the consent form and guidelines read and/or explained to you.
3. That you fully understand their contents, including the risks and benefits of telehealth counseling.
4. That you have been given ample opportunity to ask questions and that any questions have been answered to your satisfaction.

Signature: ____________________________ Date: ______________
Printed Name: ____________________________