This consent is for all telehealth services provided by UR Medicine EAP

1. I understand that my Employee Assistance Program (EAP) provider has invited me to engage in a telehealth appointment/consultation to provide assessment and short term counseling.

2. My EAP provider has explained to me that video conferencing technology will not be the same as a direct patient provider visit due to the fact that I will not be in the same room as my EAP provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my problem and that all possible precautions will be taken to minimize these risks. In addition, my EAP provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telehealth connection is not adequate for decision-making or for implementing management of my issue(s). In that event, we will complete the session by phone or schedule an in-person appointment at the EAP location where adequate assessment and short term counseling can be provided,

CLIENT E-MAIL CONSENT FORM

Client Name: _____

Client E-mail: _____

Personal Representative*:
Name: _____