Child's Name: _____ DOB: _____

WELCOME TO TELEHEALTH AT THE LIFE HEALTH CENTER

Introduction:

Telehealth involves the use of electronic communications to meet the needs of individual patients not limited to family or group setting. Telehealth is similar to Skype or FaceTime where you will be able to see your medical/mental health provider with a mobile app or by using a desktop, laptop or tablet. This is a HIPAA approved method of care. The information may be used for:

- Diagnosis
- Therapy
- Follow-up consultation
- Education

Telehealth will allow patients to obtain medical/mental health care despite their location. This is a billable service to your insurance company. Applicable copays, deductibles, and coinsurances may apply unless you are a consented school based wellness client. Please speak to your insurance carrier for further information.

Benefits:

• Timely Access to medical/mental health care
• Improved healthcare due to access
• Decreased traveling cost
• Secure and private

Although the Life Health Center has implemented protocols to mitigate issues there are:

Possible Risks:

• Delays in evaluation or treatment could occur due to deficiencies or failures of the equipment
• In very rare cases, security practices could fail, causing privacy of personal medical information to be exposed

The Life Health Center is still open to support children and families. Come to 222 Philadelphia Pike or 1624 N. Jessup Street to access physical health, mental health, and social services. If you have any other questions or concerns, please feel free to call our offices at Jessup Street office at **(302) 552-3574** or Philadelphia Pike **(302) 407-5316.**

Child's Name: _____ DOB: _____

TELEHEALTH INFORMATION FORM (NEW CLIENT)

If you would like your child to participate in the Life Health Center Telehealth Program, please complete.

Student Name _____ Date of Birth___/___/___ Sex: ☐ Male ☐ Female

Address _____
Street *City* *State* *Zip*

School_____ **Teacher**_____ **Grade**_____ **Room**_____

What is your child's ethnic background?

☐ Black/African-American
☑ Hispanic: ☐ Mexican ☐ Puerto-Rican ☐ Cuban ☐ Dominican ☐ Other _____
☐ White/Non-Hispanic
☐ Middle Eastern or African
☐ American Indian
☐ Asian/Pacific Islander
☐ Multi-racial
☐ Other _____

Best ways to contact you:

	Legal Guardian #1	**Legal Guardian #2**
Name		
Home phone number		
Best time (Select one)	Morning ◯ Afternoon ◯ Night ◯ Anytime ◯	
Cell phone number		
Email address		
Best Language?	☐ English ☐ Spanish ☐ Other _____	☐ English ☐ Spanish ☐ Other _____

What is your child's health insurance? ☐ None ☑ Medicaid ☐ Private

_____

Insurance Carrier Policy Number Group Number

Child's Name: _____ DOB: _____

LIFE HEALTH CENTER CONSENT FOR TELEHEALTH SERVICES

Client Name: _____

DOB: _____

By signing this form, I, _____, affirm that I am the legal guardian of _____ understand the following:

1. I understand my medical/mental health provider wishes me to engage in telehealth consultation.
2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
3. I understand that I have the right to withhold or withdraw my consent for telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand there are potential limits to this technology, including interruptions and technical difficulties. I understand the telehealth session can be stopped if my medical/mental health provider or I does not deem it meeting necessity.
5. I understand that my healthcare information may be shared with other individuals for scheduling or billing purposes.
6. I understand that it is my duty to inform my medical/mental health provider of interactions with other healthcare providers.
7. I have had the alternatives to telehealth consultation explained to me. I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

This form is valid for 365 calendar days from the date of execution.

Time Limit & Right to revoke authorization: I understand that this authorization is valid for one year from the date of its signing or until discharge from The Life Center Complex, Inc. I may withdraw this authorization at any time by notifying the organization in writing. I also understand that by signing this release below, I am also authorizing The Life Center Complex, Inc. to engage in telehealth services.

_____ _____

Adult Client or Legal Guardian if a Minor (Print and Signature) Date

_____ _____

LHC Witness (Print and Signature) Date

*For Electronic Senders-Sending this authorization for services form using the Life Health Center website is secured by Caldera Forms and Word Press using a HIPAA compliant encryption program. Please note that sending this form or any other medical form using an unsecured method of delivery can compromise the safety and security of protected medical information. Life Health Center will not accept or be responsible for forms sent using an unsecured method of delivery.