Telehealth Consent Form

Patient Name: ___________________________________ **Record #**: ______________

1. I understand that the service of telemedicine will be provided only under circumstances such as living in remote/rural areas, having special needs, lack of transportation and/or accessibility, or during a national emergency.
2. My consulting therapist has explained to me how the video conferencing technology will be used to affect such a session will not be the same as a direct client/consulting therapist visit since I will not be in the same room as my consulting therapist.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that on such situations, my consulting therapist will suspend connection immediately and schedule another session. I also understand that my consulting therapist or I can discontinue the telehealth session for reasons like: if it is felt that the videoconferencing connections are not adequate for the situation, if the setting does violate privacy, etc.
4. I understand that I must have equipment and a safe place for the services to be provided to not violate privacy.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the session other than my consulting therapist only if help is required to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the session and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me; (2) ask them to leave the telehealth room: and or (3) terminate the session at any time.
6. I have had the alternatives to a telehealth session explained to me, and in choosing to participate in a telehealth session. I understand the risks and benefits that it has.
7. In an emergent session (Baker Act required) I understand that the responsibility of the telehealth consulting therapist is to advise police officers as well as my family, friends or relatives and that the consulting's responsibility will conclude upon the termination of the video conference connection.
8. I understand that for billing purposes, an authorization from my insurance company must be conceded before the session.
9. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
10. I have read this document and understand the risk and benefits of the telehealth session and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth session under the conditions described in this document.

By signing this form, I certify: that I have read or had this form read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of the procedure(s); that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

________________________________ ________________________________
Witness Signature Patient's Signature

________________________________ ______________
Witness Name and Credentials Date

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Date