

Consent to Participate in a Telehealth Consultation

Patient Name: _____

1. Telehealth

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications. I understand that my health care provider, through the Company (the “Company”), wishes me to engage in a Telehealth consultation with the Company.

2. Identity Verification

I may be expected to provide a copy of my driver's license and other identity verifying documentation requested by the healthcare practitioner before any health services are provided.

3. Privacy and Security of Communications

All electronic communications between me and the healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality. I will be responsible to secure and protect the functionality, integrity, and privacy of my hardware, files, and communication. Password protection for accessing my hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke I make. It is recommended that I schedule my sessions with the undersigned healthcare practitioner when and where I can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session. I explicitly waive confidentiality if there is another individual at my distant site while I am using Telehealth.

4. Risks Associated With Distance Services

There are privacy and security risks and consequences associated with Telehealth despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of my protected health information by unauthorized persons.

By signing this information and consent form below, I acknowledge the limitations inherent in ensuring patient confidentiality of information transmitted in Telehealth and agree to waive my privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the Company to arrange a secure line of communication.

My health care provider has provided instructions to me on how the video conferencing technology will be used.

I understand that this consultation will not be the same as a face-to-face visit since I will not be in the same room as the healthcare practitioner, and that some parts of a visit may be conducted by individuals present with me at the direction of the healthcare practitioner. I also understand individuals may be present at either location to operate the audio/video equipment and that these individuals must maintain the confidentiality of health information disclosed, or if they join I at my discretion, then confidentiality may be waived.

I understand there are possible risks of an incomplete or ineffective consultation because of the technology, and that if any of the risks occur, the consultation may terminate. The risks may include:

- a. Failure, interruption or disconnection of the audio/video connection;
- b. A picture that is not clear enough to meet the needs of the consultation;
- c. A minor risk of access to the consultation through the interactive connection by electronic tampering.

I understand that in place of this Telehealth session I may seek face-to-face consultation with a health care provider.

I understand that I will not receive any royalties or other compensation for taking part in this Telehealth session or for the authorized use of any consultation images or audio.

I release the Company, its employees, agents and assigns from any and all liability which may arise from this Telehealth consultation, the use of interactive audio/visual connections, or from the taking or authorized use of any images or audio obtained.

5. Communication Interruptions

If you are unable to connect with the physician or are disconnected during a session due to a technological breakdown, please try to reconnect. If reconnection is not possible, we will reschedule the visit if needed to complete the plan of care. If the plan of care is clear, other methods of communication may be used to confirm the visit is complete. The physician can be reached at the number listed on the website..

6. E-Mail and Text Messages

The undersigned healthcare practitioner will communicate as securely as possible. The methods used by the practice are HIPAA compliant and thus messaging will typically only be done via these compliant methods. Please do not send non-HIPAA complaint e-mails related to your diagnosis or treatment, as most electronic communications are not completely secure and confidential. Any electronic transmissions of information by me are retained in the logs of my service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. I should know that any e-mails or any communications sent online and specifically the Company website are not secure, and I assume the risks of the insecure transmission.

7. Consent to Treatment Using Telehealth and Distance Health Services

I voluntarily agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the Company to provide such care, treatment, or services as are considered necessary and advisable. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

USE OF VIDEO CONFERENCING TO RECEIVE SERVICES

There are potential risks to receiving services this way, including limits to confidentiality. There is a small risk for phone and video conferencing communications to be intercepted or disrupted (e.g., cut off due to lost internet connection). The Company will use only secure programs for these meetings, unless insecure programs are allowable by law and chosen by me and the Company, however there is always a risk that confidentiality of any electronic communication can be broken or compromised. This applies to email, phone, and text messages that I send every day as well; it is not new to this time or situation. While the Company providers will provide services in private spaces and take all precautions to maintain the confidentiality of the phone/video conference/email/text communications with me, the Company cannot guarantee that such communications will not be intercepted.

Confidentiality still applies for video conferencing services, and the Company will not record the session. The Company provider will be in a private space and make every effort to avoid or minimize interruptions. This also applies to interpreters. My provider will explain how to access and use the video conferencing tool.

I may need to use a webcam (laptop with a camera) or smartphone during the video conferencing session.

It is important to not be in a public place (library, café) and to be in a space that is as quiet and private as possible during the session. It is preferred to use a secure internet connection. If any third parties can hear or see my session due to my choice of location, I impliedly waive confidentiality.

If I have a legal guardian, we need the permission of my legal guardian for me to participate in video conference sessions.

Telehealth visits may include store and forward technology where as part of the services the information is stored at one point in time, and send and reviewed at another, as opposed to a video that is live.

HOW AND WHEN TO DISCONTINUE TELEHEALTH SERVICES

Telehealth services and care may not be as effective as face-to-face services and may not be appropriate for every situation. The Company will continually assess the appropriateness of Telehealth for me. If the Company determines that I would be better served by receiving different services recommendations for treatment and treatment providers or facilities will be provided to me. I may also communicate to my provider that Telehealth services are no longer appropriate for me. My provider will consider patient safety (e.g., suicidality) and health concerns (e.g. viral risk; mobility; immune function), community risk, and the healthcare provider health when deciding whether to provide services, remote or in person.

VERBAL CONSENT

Verbal consent may be accepted in place of written signatures, if allowable by law, and only if there was a technical glitch. Paper copies can be mailed by request.

Records will include the statement, “Consent obtained verbally due to current health and safety concerns related to COVID-19 pandemic. Company will make efforts to obtain new forms with written signatures once we return to face to face service delivery.”

I can revoke consent to this Agreement at any time. If consent is revoked or not given, services may be interrupted during the time that Company staff and many others are working remotely due to the public health emergency.

If I give verbal consent for communication with other service providers or members of my care team, I may withdraw consent at any time.

Patient/Representative Signature

Date

Relationship to Patient

Witness Signature if applicable