

## CONSENT TO RECEIVE TELEHEALTH CARE SERVICES

PATIENT INFORMATION			
<b>Patient Name:</b>	First	MI	LAST <b>DOB:</b>
<b>Site Where Patient is Located and Seen Via Telehealth:</b>			
<b>Consulting Provider Name Seeing Patient via Telehealth:</b>		<b>Provider Location:</b>	
INTRODUCTION			
<p>You are going to have a clinical encounter using interactive audio and visual electronic systems with a health care provider. You will be able to see and hear the provider, and he/she will be able to see and hear you, just as if you were in the same room. Providing care in this manner ("telehealth") is an accepted means of providing services to you.</p>			
<p><b>Expected Benefits:</b></p> <ul style="list-style-type: none"> <li>Improved access to care by enabling you to obtain services from health care providers at distant sites.</li> <li>You remain in your location and avoid travel.</li> <li>Continuity of care during your health care episode, as appropriate.</li> </ul>			
<p><b>The Process:</b></p> <p>You will be introduced to the health care provider and anyone else who may be in the room. If you are unsure of what is happening, you may ask questions of the health care provider. If you become uncomfortable with seeing the provider using the telehealth technology, you may stop the visit and schedule a traditional face-to-face encounter at a time when the clinic is again accepting inpatient visits, or you may be referred to another provider. Safety measures are being used to secure the telehealth encounter, and no part of the encounter may be recorded without your express written consent.</p>			
<p><b>Possible Risks:</b></p> <p>There are potential risks associated with the use of telehealth which include, but may not be limited to:</p> <ul style="list-style-type: none"> <li>A health care provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits with this or another health care provider.</li> <li>Technology problems may delay medical evaluation and treatment for an encounter.</li> <li>Security protocols could fail, causing a breach of privacy of personal information. You will be promptly notified in the event a security issue arises.</li> </ul>			
<p><b>By Signing this Form, you understand that:</b></p> <ol style="list-style-type: none"> <li>1. You have the right to withdraw your consent to the use of telehealth in the course of your care at any time, without affecting the right to future care or treatment.</li> <li>2. If the health care provider believes you would be better served by a traditional face-to-face encounter, the health care provider may, at any time, stop the telehealth visit and schedule a face-to-face visit or refer you to another health care provider for a face-to-face visit.</li> <li>3. Technology problems may necessitate an in-person visit.</li> <li>4. You may expect the anticipated benefits from the use of telehealth in your care, but no results can be guaranteed or assured.</li> <li>5. The laws that protect privacy and confidentiality of medical information also apply to telehealth.</li> <li>6. You may be responsible for any copayments or coinsurances that apply to the telehealth visit.</li> </ol>			
<p><b>Patient Consent to the Use of Telehealth:</b></p> <p>I have read and understand the information provided above regarding telehealth, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care. I also consent to a recording of this telehealth encounter being taken and stored in my patient file.</p>			
<p>I hereby authorize _____ to use telehealth in the course of my diagnosis and treatment. (practitioner name)</p>			
<p>Signature of Patient (or authorized person) _____ Date/Time _____</p>			
<p>If authorized person, relationship to patient _____</p>			
<p>Witness _____ Date/Time _____</p>			