TELEHEALTH INFORMED CONSENT FORM

Patient Name: ________________________________ DOB: ______________________________
Insurance Policy: __________________________________ SS# _______________________________
Consulting Provider Name Seeing Patient via Telehealth: _____________________________________

You are going to have a clinical encounter using videoconferencing technology. You will be able to hear and see the provider and they will be able to hear and see you, via a computer. The information shared between you and the provider may be used for diagnosis, therapy, follow-up and/or education.

Intended Benefits:

*Reduction of travel for you and the provider

*Obtain additional access of services from providers at distant sites

*You can remain at home and continue to receive quality healthcare services

How it Works:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you. If you are not comfortable with seeing a provider on Video conference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are implemented to ensure that this encounter is secure, and no part of the encounter will be recorded without your written consent.

Potential Risks:

There are possible risks associated with the use of telemedicine which include, but may not be limited to:

*Technology problems may delay the medical evaluation and treatment for today's encounter.

*The provider may determine that the encounter is yielding sufficient information to make an appropriate clinical decision.

*In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a traditional face-to-face visit.
4. I understand that I may anticipate benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I agree that I may be responsible to the facility for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

Patient Consent to the Use of Telemedicine for Behavioral Health Services:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.
I hereby authorize _____**Catalyst Health & Wellness**________________ to use telemedicine in the course of my diagnosis and treatment. (Agency Name)
Signature of Patient (or authorized person) ________________________Date/Time ___________________.
If authorized signer, relationship to patient ____
Witness _______________________________________ Date/Time _______________________________