TELEHEALTH INFORMED CONSENT

To better serve the needs of the community, healthcare services are now available by interactive video communications and/or by the electronic transmission of information. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals ("Treatment Providers") at different locations to share individual client clinical information for the purpose of improving client care. Treatment Providers may include, but are not limited to, counselors and marriage and family therapists. The information may be used for healthcare delivery, diagnosis, treatment, transfer of medical data, therapy, consultation, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

Expected Benefits:

1. Improved access to healthcare by enabling a client to remain at a remote site while consulting with Treatment Provider.
2. More efficient healthcare evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

Although rare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;
3. The transmission of client's clinical information could be interrupted by unauthorized persons; and/or the electronic storage of my clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgment errors.

Necessity of In-Person Evaluation:

If it becomes clear that the telehealth modality is unable to provide all pertinent clinical information during a particular telehealth encounter, the Treatment Provider must make it known to the patient prior to the conclusion of the live telemedicine encounter. The Treatment Provider must also counsel the patient prior to the conclusion of the live telehealth encounter regarding the need for the patient to obtain an additional in-person medical evaluation reasonably able to meet the patient's needs.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
2. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to information demonstrating a probability of imminent physical injury to myself or others; immediate mental or emotional injury to myself; and where I make my mental or emotional state an issue in a legal proceeding.
   I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my consent.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. I understand that I may ask my Treatment Provider about alternative methods of care to telehealth.
6. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. I understand that it is my duty to inform my Treatment Provider of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my Treatment Provider believes I would be better served by another form of service (e.g. face-to-face services), I will be referred to a Treatment Provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Treatment Provider, my condition may not improve, and in some cases may even get worse.
9. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
10. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.
11. I understand that be. Women's Health and Wellness, PLLC will file this Telehealth visit to my insurance on file. In the instance that my insurance considers a Telehealth as a non-covered service or does not cover the visit, I understand that I am financially responsible for any amount not covered or deemed my responsibility.

In cases of life-threatening emergency, call 911 immediately

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of telehealth in my clinical care.
I hereby authorize, be. Women's Health and Wellness, PLLC, and its employees, agents and independent contractors, to use telemedicine in the course of my diagnosis and treatment.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date