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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Client's
Initials

_____I understand that telehealth involves the communication of my medical/mental health information, information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time, and if so future care will be determined at this time.

_____I understand that telehealth services can only be provided to clients who are residing in the state of North Carolina at the time of this service.

_____I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and may be governed by my insurance carrier, and it is my responsibility to check with my insurance plan to determine coverage.

_____I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

~ It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

~ Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.

~ Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____I understand that Skype, FaceTime, or similar services may not provide a secure HIPPA-compliant platform, but I willingly and knowingly wish to proceed if I choose to use one of these platforms.

_____I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

____The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

____I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

____I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that she is my healthcare provider.

____I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

____I understand that there will be no recording of any telehealth sessions by either party.

____I understand and agree that a medical evaluation via telehealth may limit my healthcare providers ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibly for following my healthcare provider's recommendations including further diagnostic testing, or an in-office visit.

____I understand that electronic communication may be used to communicate highly sensitive medical information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

____By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care if provided.

____To the extent permitted by law, I agree to waive and release my healthcare provider and her practice from any claims I may have about the telehealth visit.

____I understand that electronic communication should never be used for emergency or urgent requests. Emergency and urgent requests should be made to the existing 911 services in my community.

I certify that I have read and understand this agreement prior to my signature with the opportunity to have questions answered to my satisfaction for electronic communication between Renée Flam, LCSW, ACSW and

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client name printed client signature date