Telehealth Informed Consent Form

INTRODUCTION You are going to have a clinical visit using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. To qualify for telehealth services the patient must be an established patient and consented to telehealth services. Electronic systems used is a high quality, real-time audiovisual link using HIPAA-compliant telehealth platform to protect the confidentiality of patient identification, however as with any other technology devices, we can t guarantee confidentiality. The information may be used for diagnosis, therapy, follow-up and/or education. Expected Benefits: -Improved access to care by enabling a patient to obtain services from providers at distant sites. -Patient remains at home or closer to home where local healthcare providers can maintain continuity of care. -Reduced need to travel for the patient or other provider. The Process: You will be introduced to the provider and anyone else who is in the room with the provider. You must be in a private or isolated setting during time of session. You may ask questions of the provider or any telehealth staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time, if available. Safety measures are being implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent. Possible Risks: There are potential risks associated with the use of telehealth which include, but may not be limited to: -A provider may determine that the telehealth encounter is not yielding enough information to make an appropriate clinical decision. -Technology problems may delay medical evaluation and treatment for today s encounter. -In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. By Signing this Form, I am understanding the following: 1. I understand that the laws that protect privacy and confidentiality of mental health information and Federal confidentiality rules in 42 CFR Part 2 of substance abuse treatment information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

Patient Consent to Use of Telehealth:

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 hereby authorize SUN Behavioral to use telehealth in the course of my diagnosis and treatment.

Patient/Authorized Person Signature: _____ Date: _____

If authorized signer, relationship to patient:

_____

Verbal Consent Obtained:

Reason why verbal consent necessary: _____

Verbal consent obtained from: _____

Relationship to Patient: _____

Staff Name: _____ Staff Signature: _____ Date: _____

Time: _____

Witness Name: _____ Witness Signature: _____

Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____

Staff Signature (Credentials) _____ Date: _____ Time: _____