1520 Main Street, Suite 200 ~ Warrington, PA. 18976 ~ Phone 267-927-0020

Telehealth Consent

Patient Name: _____Program/County_____

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider has explained to me how to use my existing technology to affect such a consultation and that this will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing/phone connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history & psychological/psychiatric evaluation that are personally sensitive to me; (2) ask non-medical personnel to leave the designated telehealth room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation is voluntary.
6. In an emergent consultation, I understand that the responsibility of the telehealth consulting specialist is to advise my local emergency responders and/or strongly recommend seeking emergent consultation.
7. I understand that what is usual and customary process in submitting billing will involve the release of pertinent information to substantiate that claim.
8. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ Client Signature Date_____

_____ Parent/Guardian Signature Date_____

_____ Witness Signature Date_____