Telehealth Visit Consent Form

Overview

To better serve the needs of our clients, some clinically appropriate health care services are now available by live, two-way, interactive communication technology (which we will refer to here as "telehealth visit"), which may assist in the evaluation and treatment of health-related issues clinically appropriate for delivery through telehealth. Referred to as "telemedicine" or "telehealth," this means that you may be evaluated and treated by a Farnum Provider when participating in this service. For the purposes of this agreement, "Farnum" is used collectively to mean Farnum Center Queen City Ave., Farnum Outpatient Services, Farnum Ray House, Farnum Webster Place and any other future locations of business.

Terms of Use

- Benefits of Using the Telehealth Service
    a. Allows my Provider/Clinician to use real-time, multimedia communications equipment to communicate directly with me wherever I have access to this technology.
    b. Enhances my ability to consult with my Provider/Clinician and receive medical/clinical advice in a time-efficient, convenient manner.
- Potential Risks in Using the Service

  As with any medical/clinical interaction, there are potential risks associated with the use of telehealth visits. Farnum believes that the likelihood of these risks happening is very low. These risks may include, without limitation, the following:
    a. A poor connection may reduce my Provider's/Clinician's ability to perform a proper examination, and may affect the assessment or diagnosis of my condition and recommended treatment;
    b. My Provider/Clinician will be limited to the information or images I provide him/her, which may reduce my Provider's/Clinician's ability to make an accurate diagnosis/treatment recommendation;
    c. Delays in evaluation, consultation or treatment may occur due to problems with technology;
    d. Security protocols could fail, causing a breach of privacy for personal health information.
- Notice of Privacy Practices

  The laws protecting privacy and the confidentiality of medical information also apply to telehealth visits. You may review the Farnum Notice of Privacy practices at www.farnumcenter.org.
- Privacy and Security

  The service upholds patient privacy and confidentiality laws with respect to protected health information as outlined by the Health Insurance Portability and Accountability Act (HIPAA). Subject to HIPAA and 42 CFR Part 2 regulations, the Service will obtain your consent prior to sharing any patient-identifiable information to a third party for purposes other than treatment, payment, or health care operations. Disclosure without consent may occur in accordance with 42 CFR Part 2 and HIPAA regulations.

- I understand that use of the Telehealth Service requires the electronic exchange of my medical information from one place to another. I understand that I will access the Service to transmit my health information and consult with my Provider/Clinician at Farnum.
    a. I understand that secure transmission of my information cannot be guaranteed and that electronic exchanges may experience errors, delays, disruptions, or distortions. However, I

understand that Farnum has taken precautions to minimize these occurrences and will protect the security of the information and keep it confidential in accordance with the law.

b. I have read this document carefully and understand the risks and benefits of the telehealth visit consultation. I have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth visit under the terms described herein.

Client Authorization

I hereby authorize a Farnum Provider to use telehealth visit services for direct consultation with me via interactive communication technology in order to assist my Provider in making decisions about my care.

- I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare Provider to discontinue the conference at any time.
- I understand that some parts of the examination involving physical tests may require a referral to other Providers/Clinicians near my geographic location.
- I understand that, regardless of any telehealth visit consultation services I may receive, my condition may require a referral to the clinic or specialist for further evaluation and treatment.
- I understand that my Provider may bill for his/her professional services and for any additional fees in connection with the consultation services described above. I understand that if my insurance does not cover telehealth services, I will be billed directly for the provision of telehealth services.
- I understand that I may revoke my consent to participate in the Service at any time by notifying my Provider/Clinician in writing. As long as this consent is in effect, my provider/clinician may provide health care services to me via the Service without the need for me to sign another consent form.
- I agree to permit individuals other than my healthcare provider to be present during my telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth service.
- I agree that there have been no guarantees or assurances made about the results of this service.
- My consent to participate in this telehealth service shall remain in effect for one (1) year unless otherwise stipulated. _____(revised expiration date)
- I confirm that I have read and fully understand the above. I have had an opportunity to ask questions.

_____ _____
Client Name Printed Date

_____
Client Signature

_____ _____
Guardian Name Printed Date

_____
Guardian Signature