Telemedicine HIPPA, Consent, and Privacy Form

I understand and agree to participate in a telemedicine encounter with a provider at American Behavioral Clinics and I understand and agree to the use of said telehealth functionalities in my care.

Risks of participating in a telemedicine visit include, but may not be limited to:

1. The connection may fail to work or may be disconnected during an encounter which might result in delays of care.
2. If it is felt that the care rendered during the visit is not sufficient to appropriately address my problem or provide adequate care, I may be required to see my provider in person.
3. In very rare instances, security protocols could fail causing a breach of privacy of personal and medical information. In these situations, my providers will utilize any and all means necessary to correct the error as outlined in the policies related to HIPPA and Privacy and will notify me of the status of such breach and attempts at my correction.
4. My insurance may not cover telemedicine services and I may be required to pay for such service.

Benefits of participating in a telemedicine consult include:

1. I will have access to psychiatric providers without the costs associated with travel.
2. I will be able to stay close to home and in proximity to my family and caregivers.
3. Telehealth will continue to grow and be widely utilized by my providers in the future.
4. Telehealth reduces overall costs of medicine and is beneficial for patients, insurers, and providers.
5. The technology needed to perform telemedicine is constantly improving.

I understand that ancillary staff, nurses, medication assistants, nurse practitioners, therapists, doctors and other such healthcare employees may be present during the telehealth visit whose presence may be required for the purposes of obtaining an adequate intake, history, examination, or operating equipment. I understand that I have the right to discontinue the telehealth encounter at any time without it affecting my right for further care or treatment. I understand that any and all laws related to medical practice, privacy, and confidentiality also apply to telemedicine.

I have read this document and understand the risks and benefits as listed above and have had my questions adequately answered. I hereby consent to participate in said telemedicine visit under the conditions described in this document.

_____

Printed Patient Name

_____ _____ _____

Patient/Legal Representative Signature Relationship Date

_____

Witness

For office staff only: _____ Entered into Computer