Healing Hands For ADHD
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Informed Consent for Telemedicine Services

Patient Name:
DOB:

About Telemedicine:

Telemedicine involves the use of electronic communication technologies by health care providers to deliver health care services to a patient when the patient and provider are at different locations.

I understand the following:

Telemedicine visits are generally not recorded, and video, audio, or images are not electronically stored. My provider will obtain my authorization to record if he/she recommends recording the visit for my record.

Laws that protect privacy and confidentiality of medical information also apply to telemedicine.

The doctor will bill my health care insurance for telemedicine services, and I will be responsible for any co-payments that apply to my telemedicine visit. I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without jeopardizing access to other available services or affecting my right to future care or treatment.

I may revoke my consent orally or in writing at any time by advising my health care provider. If I do not revoke my consent, my health care provider may provide health care services to me via telemedicine without the need to sign a consent for each telemedicine encounter. Electronic systems used will incorporate security protocols, in accordance with federal law, to protect the confidentiality of patient identification and information and will include measures to safeguard against electronic interception of the communication; however, no guarantees have been provided.

Benefits: Potential benefits of telemedicine incudes improved access to health care.

Risks: I understand that there are potential risks associated with the use of technology for telemedicine services, including but not limited to:
The video connection may not work, or may stop working during the telemedicine visit; The video or sound may not be clear enough to be useful to effectively complete the telemedicine visit; I may need to reschedule an in-person visit if the health care provider believes the information able to be obtained during the telemedicine visit is not sufficient; Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; Security protocols could fail, causing a breach of privacy of personal medicine information.

Certification of Patient:
By signing below, I certify that I have been instructed on accessing telemedicine services and have had an opportunity to ask the health care provider all my questions concerning anticipated benefits, and potential risks, and all of my questions have been answered to my satisfaction. I hereby consent to having my health care provider provide health care services to me via telemedicine and accept any associated risks.

Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____

Patients over 14 yo name: _____

Patients over 14 yo Signature:_____

Certification of Health Care Provider:

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, potential risks, and additional information described in this consent.

Name of Licensed Health care Provider: _____

Signature of Licensed Health Care Provider: _____