Informed Consent to Participate in Telemedicine Services

I, _____, have been asked to receive behavioral health services for myself (or my child) via telemedicine. I have been informed of my (or my child's) diagnosis and proposed telemedicine treatment plan. I understand that I will be receiving health care services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care this way.

I understand that my participation in telemedicine is voluntary and I may refuse to participate or decide to stop participation at any time, verbally or in writing. I understand that my refusal to participate or decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of my revocation of informed consent to treatment.

I understand that my privacy and confidentiality will be protected. I also understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. When I am receiving services via telemedicine, I will be notified as to who is in the room at the remote site.

I understand that the videoconference will include access to my medical information including psychiatric information, alcohol and/or drug abuse, and mental health records.

I have read this document and I hereby consent to participate in receiving behavioral health services via telemedicine under the terms described above. I understand this document will become a part of my medical record. I understand that all office financial policies apply to telemedicine services.

_____ _____

Patient Printed Name Date

_____ _____

Behavioral Health Recipient/Guardian Printed Name Signature

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