

### **Tele Health Informed Consent**

I, \_\_\_\_\_, hereby consent to participate in telehealth with, Wayne Neurology, PLC, as part of my treatment. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to telehealth:

- 1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- 2) I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- 3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- 4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- 5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate and a higher level of care is required.
- 6) I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call at 734-721-4739 to discuss since we may have to re-schedule.

- 7) I understand that my doctor may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**Emergency Protocols**

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: \_\_\_\_\_

and my emergency contact person's name, address, phone: \_\_\_\_\_

\_\_\_\_\_

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

\_\_\_\_\_  
Signature of client/parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date