Ivyland Counseling Center
1210 Old York Road • Suite 202 • Warminster • PA 18974 • 215.444.9204

INFORMED CONSENT FOR THE USE OF ELECTRONIC MEDIA COMMUNICATION

Telemedicine: Telemedicine is the use of electronic/internet/data transmissions to treat the needs of a client. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Examples of these include, but are not limited to: e-Mail, cell/mobile/VoIP calls, voice-mail, text messaging, Skype, social media sites, and other non-face-to-face interactions.

INFORMED CONSENT

By selecting and signing below, you acknowledge that there are logistical and privacy issues that may or may not be compromised in the use of such systems. We, (Ivyland Counseling Center (ICC), and your clinician), will continue to abide by the HIPAA/PHI standards you have received as part of your Initial Intake Packet. However, please read the following section to show your understanding:

(1) YOU, "the client", retain the option to withhold or withdraw consent to telemedicine at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which YOU would otherwise be entitled.

(2) The risks involved with Telemedicine include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overhead by anyone near you if you do not place yourself in a private area and open to other's intrusion.

The advantages of Telemedicine include the benefit of continuity of care in the absence of your clinician as well as the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the Telemedicine transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is OUR responsibility for the clinician to do the same.

(3) All existing confidentiality protections apply as noted in your HIPAA/PHI information portion of your Initial Intake Packet.

(4) All existing laws regarding client access to medical information and copies of medical records apply.

(5) Dissemination of any client identifiable images or information from the telemedicine interaction to researchers, individuals, physicians, or other persons and entities shall not occur without YOUR consent.

(6) YOU acknowledge that you have both received a copy of this Consent form and have given both written and verbal consent to utilizing Telemedicine as part of your treatment.

(7) The written consent statement signed by YOU shall become part of YOUR medical record.

(8) The failure of any health care practitioner to comply with the above shall constitute unprofessional conduct.

(9) All existing laws regarding surrogate decision-making shall apply. For purposes of this section, surrogate decision-making means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(10) The Clinician will discuss with YOU any fees associated with the use of Electronic Media Communication

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ACKNOWLEDGMENT OF the RISKS and BENEFITS of THE USE OF TELEMEDICINE:

I/We, _____, have read the above-mentioned Telemedicine Services and Informed Consent and have chosen the following method of communication in the event that I/We schedule to speak to our clinician via Telemedicine:

____ Video Conference (Via Skype or other form available to me)
____ Telephonic (cell phone usage, text messaging, voice-mail)
____ e-Mail usage
____ No preference
____ I do not wish to participate

I/We understand that there are both risks and benefits as mentioned within this consent form as well as others that I/We may not fully be aware of that can occur with or without our knowledge.

I/We understand that the clinician will use their best efforts to conceal personal information and abide by HIPAA/PHI standards.

I/We will use our best efforts to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information.

I/We understand that there are no universal protocols or protective standards in the use of Telemedicine and I/We, will hold ICC, its clinician, officers, and employees, harmless and free from liability in the event I/We use this method of communication and engage My/Our clinician to receive communication in this manner.

I/We agree that we have been verbally informed in addition to this written informed consent regarding the use of Telemedicine as a means of facilitating My/Our therapy sessions.

Client Signature(s) and Date _____

Clinician Signature and Date _____

REVOCATION OF TELEMEDICINE AUTHORIZATION:

In the event you decide to revoke your authorization and informed consent, please complete the following and fax it to 215-444-9206. It will be placed in your file.

I/We, _____, revoke our prior authorization and informed consent to use Telemedicine as a means of therapy.

I/We further understand that in the event I/We use Telemedicine after this revocation and fail to inform our clinician of our revocation, then such revocation shall become null and void and a new revocation will be required.

Client Signature(s) and Date _____

Clinician Signature and Date_____