Telehealth Consent Form

I, _____ (name of patient), do hereby consent to engaging in a telehealth appointment with Lesa Werner, ND, a licensed naturopathic physician in the state of Connecticut. I understand that Telehealth (aka telemedicine) appointments include, but are not limited to, the practice of education, accountability, referral to resources, setting goals, skills training, and help with treatment decision making. Telehealth health care delivery can include consultation, coaching, and/or counseling. Telehealth medical appointments with Dr. Lesa Werner will only occur using Clocktree, a secure, HIPAA-compliant platform.

I understand that I have the following rights with respect to telehealth:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during my telehealth sessions with Dr. Werner is generally considered confidential. However, there are both mandatory and permissive exceptions to confidentiality; including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; to insurance companies, and during legal proceedings.
3. I also understand that the dissemination of any personally identifiable images or information from a telehealth interaction to other entities shall not occur without my written consent. I have also read and signed a separate HIPAA consent form,and understand that all HIPAA considerations will also apply to telehealth video conferencing.
4. I understand that utilizing a telehealth consultation has some LIMITATIONS, including, but not limited to, the inability of the doctor to perform a physical exam (e.g. heart rate, temperature, blood pressure readings, auscultation of heart, lungs, stomach, blood vessels, ocular examination, etc.) because access to standard equipment (e.g. BP cuff, stethoscope, otoscope, heart monitor, reflex hammer, etc) used during an in-person office visit are not available for use during a telehealth video-conferencing appointment. In addition, the doctor is also unable to visualize discrete details such as accurate skin color, or details of lesions on skin, in throat, in ears, and/or any other body parts due to limitations of the technology used by patient and/or doctor. Also, during a telehealth consultation the doctor will be unable to assess skin temperature and texture, assess swollen glands, pain, etc., by palpation (touch).
5. I understand that there are risks and consequences from using telehealth and other electronic means of communication including, but not limited to, the possibility, despite reasonable efforts on the part of the physician, that the transmission of my personal information could be disrupted or distorted by technical failure's; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons in the

unlikely event of a hacking attack. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my physician believes I would be better served by another form of intervention (e.g. face-to-face services), I will be referred to a health professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of medicine, and that despite my efforts, and the efforts of my physician, my condition might not improve, and in some cases may even get worse.

6. I understand that I may benefit from telehealth health care services, but that results cannot be guaranteed nor assured. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with respect to outside hacking events and issues inherent in any electronic communication systems. Signing this form shows an awareness of these issues and a decision by me to use Clocktree telehealth services for video conferencing. I will not hold Dr. Werner liable for any gathering or use of my information by an unexpected hacking event.
7. I understand that I have the right to access my personal information and copies of case records in accordance with Connecticut law. I have read and understand the information provided above and I have discussed it with my physician, and all my questions have been answered to my satisfaction.
8. By signing this document, I agree that certain situations including emergencies are inappropriate for audio/video telehealth medical services. If I am in crisis or in an emergency health situation, I will immediately call 911, and/or seek help from a hospital or other healthcare facility in my immediate area.

By signing below, I acknowledge reading and understanding the terms of this document regarding my participation in a telehealth appointment.

_____

Signature of patient/parent/guardian date

_____Printed

name of patient/parent/guardian date

_____

Signature of telehealth physician date