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Informed Consent for Telehealth Services

Effective Date: ___ / ___ / _____

This **Informed Consent for Telehealth Services** ("Consent") is designed to inform you about telehealth services provided by **Abide Health Medical APC**, and to obtain your consent to participate in telehealth consultations and treatment via electronic means. By signing this form, you acknowledge your understanding of the following aspects of telehealth.

Please review this document carefully. If you have any questions or concerns, feel free to ask your provider before signing.

1. Purpose of Telehealth Services

Telehealth refers to the use of electronic communications to enable healthcare providers to deliver care remotely. These services may include:

- **Video conferencing**
- **Telephone consultations**
- **Electronic transmission of medical records**
- **Remote monitoring of health data**

The purpose of telehealth is to provide you with access to healthcare services when in-person visits are not feasible or required. This may include services related to mental health, medical consultations, medication management, or other forms of healthcare delivery.

2. Potential Benefits of Telehealth

Telehealth offers several potential benefits, including but not limited to:

- Increased access to healthcare services, especially for those in rural or underserved areas.
- Convenience, by eliminating the need for travel and allowing consultations from home or another location.
- The ability to receive care during times when in-person visits may not be possible (e.g., during illness, or emergencies).

3. Potential Risks of Telehealth

While telehealth is generally considered safe, it does have some inherent risks:

- **Confidentiality**: There is a risk of information being intercepted, as telehealth involves electronic communication. While we implement security measures, we cannot guarantee complete privacy.
- **Technical Issues**: There may be interruptions in service due to technical issues such as internet connectivity problems, software malfunctions, or power outages.
- **Miscommunication**: Remote communication may increase the possibility of miscommunication due to limitations in visual or auditory cues.
- **Emergency Situations**: In the event of an emergency, telehealth is not appropriate. If you are experiencing a medical or psychiatric emergency, you should call 911 or visit the nearest emergency department.

4. Confidentiality and Privacy

Your healthcare provider will follow the same confidentiality protections for telehealth as for in-person services. This includes compliance with the **Health Insurance Portability and Accountability Act (HIPAA)** and **Nevada state law** regarding the privacy of your health information. Your health information will be transmitted securely and stored in accordance with applicable laws.

However, please note that no electronic communication can be 100% secure, and there is a risk of breaches. By consenting to telehealth, you acknowledge this risk.

5. Technology Requirements

To participate in a telehealth session, you must have access to:

- A **computer, tablet, or smartphone** with a camera and microphone.
- A **stable internet connection**.
- A secure **location** where you can participate in the session without interruptions.

We will provide instructions for how to connect to your telehealth appointment prior to your scheduled session.

6. Your Rights and Responsibilities

As a patient, you have the following rights and responsibilities:

- **Right to Refuse**: You have the right to refuse telehealth services at any time and opt for in-person care.
- **Right to Confidentiality**: Your health information will be treated confidentially, in accordance with HIPAA and Nevada law.
- **No Guarantee of Success**: While telehealth services aim to provide high-quality care, there is no guarantee of specific outcomes or results.
- **Emergency Care**: Telehealth services are not appropriate in case of emergencies. If you have an urgent medical condition, you should seek in-person care immediately.

7. Consent to Telehealth Services

By signing below, you acknowledge the following:

- You understand the nature, purpose, and potential risks of telehealth services.
- You consent to receiving telehealth services, including the use of audio/video technologies for remote consultations.
- You understand that telehealth services are provided in accordance with Nevada law, and that your healthcare provider will maintain the confidentiality of your health information in compliance with HIPAA.
- You understand that you have the right to withdraw consent at any time without affecting your future access to care.

8. Acknowledgment of Telehealth Fees and Insurance

You acknowledge that telehealth consultations may be billed to your insurance provider or paid directly, as applicable. The terms and conditions for billing will be discussed with you prior to the appointment, and you are responsible for understanding your financial responsibilities regarding telehealth services.

9. Consent for Recording (if applicable)

Telehealth sessions may be recorded for the purposes of clinical supervision, training, or quality assurance. You will be informed in advance if a session is being recorded, and you have the right to decline being recorded.

- **Do you consent to recording of your telehealth sessions for the purposes of supervision and quality assurance?**
  ☐ Yes
  ☐ No

10. Emergency Procedures

In the event of an emergency during a telehealth session, the provider will direct you to the appropriate emergency services if necessary. It is recommended that you provide an emergency contact number during the scheduling of your telehealth appointment.

11. Consent to Participate in Telehealth Services

By signing below, I acknowledge that I have read, understood, and agree to the information provided in this Informed Consent for Telehealth Services form. I consent to receive telehealth services as described and acknowledge the potential risks and benefits.

- **Patient Name (Printed): _____**
- **Date of Birth: ___ / ___ / _____**
- **Patient Signature: _____**
- **Date: ___ / ___ / _____**

For Parent/Guardian (if applicable):

If the patient is a minor or unable to provide consent, the following should be completed by the parent/guardian:

- **Parent/Guardian Name (Printed): _____**
- **Relationship to Patient: _____**
- **Parent/Guardian Signature: _____**
- **Date: ___ / ___ / _____**

Provider's Signature:

- **Clinician Name (Printed): _____**
- **Provider's Signature: _____**
- **Date: ___ / ___ / _____**

Clinic Use Only:

- **Date Form Received: ___ / ___ / _____**
- **Entered into System (Date/Initials): _____**
- **Notes (if any): _____**