Beach Counseling Center LLC

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Consent to Participate in a Telehealth Consultation

Provider's Name_____ **Provider's Credentials**_____

Patient Name: _____ Date of Birth:_____/_____/_____

1. I understand that my health care provider wishes for me to engage in a telehealth consultation. I hereby consent to forward my patient-identifiable information to a third party for HIPAA compliant video conferencing. I understand that it is the role of the health care provider to determine whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
2. My health care provider has explained to me how the video conferencing technology will be used and that telehealth services can include, appointment scheduling, taking payment, patient education, or psychotherapy, despite not being in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that all audio, video, file sharing, and chat features will require password protection and use the latest encryption protocols to assure that data integrity and privacy is maintained. I will hold the health care provider harmless for information lost due to technical failures. I agree to use landline or cellular telephones as an alternate means of communication should teleconference service be interrupted.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation, I also understand that some parts of the consultation may require an in-person office visit.
6. In an emergent consultation, I understand that the responsibility of my health care provider to notify my local providers or emergency services and that my health care provider's responsibility will conclude upon the termination of the video conference connection. It is my responsibility to notify my provider of my physical location during each meeting.
7. I understand that billing will occur just the same as in-person visits and I am responsible for all charges not covered by my insurer as per the previously signed financial agreement.
8. I have had a direct conversation with my health care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits have been discussed with me in a language in which I understand.

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient/Parent/Guardian Signature Date Time