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**CONSENT FOR TELEHEALTH SERVICES**

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation would not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand this technology has potential risks, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. Although many physical exam elements may be conducted using telehealth technology, I understand there are limits to a comprehensive physical exam. Should the provider or I believe that a more in-depth physical exam is needed, I would need to seek an alternative provider or work with my provider for a referral to an in-person provider.
6. I understand that the provider will confirm my location at each visit in the event that an emergency arises.
7. I understand that visits will only be conducted using audio and visual technology. **I understand that I must be present on camera for a visit to be conducted.**
8. I understand that I am responsible for ensuring my privacy during each visit. If I cannot secure a private area, I will work with my provider to reschedule the appointment to a date and time when I can be reasonably assured of privacy.
9. Due to the nature of the interaction of a telehealth visit, I agree to be fully engaged in the session and not attempt to multi-task (such as working or driving during a visit) to ensure adequate interaction with my provider.

10. **I understand that no elements of the telehealth visit will be recorded or saved except for notes made by my provider in my electronic health record.**
11. **I agree not to record any visit or portion of the visit unless mutually agreed upon with my provider.**
12. I understand that "Advancing Wellness in Psychiatry, Nurse Practitioner Services, LLC" does not currently offer in-person services. Should I or my provider believe that in-person services would have better health benefits, I would need to seek an alternative provider or work with my provider for a referral to an in-person provider.
13. I had a direct conversation with my provider, during which time I had the opportunity to ask questions concerning this procedure. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

**CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE SERVICE**

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use, and no passwords are required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service, and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice, including emergency or urgent medical services.
3. Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for delivering any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate, or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone who is unauthorized to attend the appointment.

By signing this form, I certify:

Advancing Wellness in Psychiatry

Nurse Practitioner Services, LLC

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- That I have read or had this form read and/or had this form explained to me.
- I fully understand its contents, including the procedure's risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and any questions have been answered satisfactorily.

BY SIGNING BELOW, I AGREE THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.