NJ License # 44SC05440500
Florida License # 20498
NPI: 1366955528

Telehealth Appointment Consent Form

This consent is for all telehealth services provided to me by Megan Lukany, LCSW.

Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators.

Specifically, a health care professional will be communicating with me remotely via the Internet using doxy.me web-based audio-video software (referred to in this form as Telehealth Appointment). Doxy.me only hosts the software and does not provide medical advice or information.

This Telehealth Appointment may be for diagnosis, continuity of care, treatment, testing, or medical consultation deemed necessary by my Healthcare Provider or me.

I understand that during a Telehealth Appointment

- details of my medical history and personal health information may be discussed with me and/or other health professionals;
- audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record;
- all confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment;
- industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption;
- there may be security and privacy risks associated with Internet-based communications;
- there are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider;
- either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate for diagnostic decision-making or for providing the care I desire;

- in addition to my Healthcare Provider named above, I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area;
- to maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment;
- due to the limitations of telehealth that are out of my control (such as an unreliable internet connection), I will call local authorities (9-1-1) to assist me with a medical emergency;
- I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive;
- my Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me;
- the communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

THEREFORE, BY CONSENTING TO THIS TELEHEALTH APPOINTMENT:

1. I desire to engage in remote audio-visual communication with my Healthcare Provider.
2. I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
4. I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment.
5. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider.

6. I understand I have the ability
7. to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider''s privacy policy. And if my questions are not answered to my satisfaction, I have the right to terminate the appointment.
8. I certify that I am at least 18 years of age or the age of consent for treatment in my state or my legal guardian has consented to this treatment.

Patient Name (printed) Date

Signature of patient

Signature of Legal Guardian Date