CHANCE CHANGE

WELLNESS SPA

Patient Consent to Telemedicine Services – COVID-19

PLEASE READ EACH SECTION CAREFULLY. YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.

In order to reduce possible exposure to COVID-19 (Coronavirus), Chance to Change is implementing:

- Telemedicine virtual visits via audio-visual, real-time, two-way interactive communication system for new and established patients.
- Virtual check-ins by telephone and/or audio-visual, real-time, two-way interactive communication for established patients; and
- E-visits via online patient portals for established patients.

THIS IS A TEMPORARY MEASURE IN RESPONSE TO THE COVID-19 NATIONAL HEALTH EMERGENCY.

I, the undersigned, do hereby request and consent to an evaluation and treatment via telemedicine technologies by Chance to Change and its staff.

I understand that telemedicine is being utilized during the COVID-19 pandemic to reduce potential exposure to the virus, and that face-to-face encounters in accordance with applicable law will resume once the risks associated with the virus have been minimized.

I understand that although [*Practice or Provider*] has taken reasonable steps to protect my privacy, because this is in response to a national health emergency, telemedicine services may not comply with all of the HIPAA privacy and security requirements. Specifically, Chance to Change will deliver telemedicine health care services using the following platforms: TEBRA & Practice Fusion.

I understand that I have the right to withdraw consent at any time before or after the consult without affecting my right to future care or services from Chance to Change.

I understand that there are risks and consequences associated with receiving clinical health care services via telemedicine communication that are beyond Chance to Change's control, including, but not limited to disruption of transmission by technology failures, poor image quality, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

I understand that, in lieu of this telemedicine encounter, I may seek health care services elsewhere, where I might have face-to-face contact with a health care provider.

I understand there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

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I understand that the privacy laws of confidentiality of my protected health information ("**PHI**") also apply to telemedicine health care services unless an exception to confidentiality applies or is required by law.

I wish to rely on Chance to Change to exercise judgment for my best interest during my course of treatment during the COVID-19 national health emergency. I will inform Chance to Change Staff of any sensitive areas or adverse conditions that I may have had prior to, during or after treatment. I intend this consent to cover my entire course of treatment during the COVID-19 national health emergency.

I understand that any questions I may have regarding the potential side effects, complications, treatment or treatment area may be directed to [*Practice or Provider*] during my evaluation and course of treatment during the COVID-19 national health emergency.

I clearly understand and agree that all services rendered to me may be charged directly to me, and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me, up to the point of termination, will be immediately due and payable.

I agree to inform [*Practice or Provider*] of my location in case of an emergency. I also agree and consent that the emergency contact listed below may be contacted by [*Practice or Provider*] on my behalf in a life-threatening medical emergency only. I agree and consent that the emergency contact may be notified of my location to transport me for emergency medical services to a hospital or emergency medical facility in the event of a medical emergency during the course of my treatment by [*Practice or Provider*] during the COVID-19 national health emergency.

In case of an emergency, my location is: _____ and my

emergency contact person's name, address, and phone number is:_____

_____

_____ _____

Printed Patient Name **Signature of Patient/Personal Representative**

_____ _____

Relationship to Patient **Date**

Practice Representative Name	**Signature of Practice Representative/Witness**