Telehealth Consent
Space Coast Psychiatry, Inc.

Client Name: _____DOB: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using a HIPPA Compliant telehealth platform.

2. My health care provider, or the staff, have explained to me how the video conferencing technology will be used and I understand I will not be 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 understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.

6. In a crisis, I understand that the responsibility of the telemedicine specialist is to advise my local first responders, and coordinate any care deemed necessary to address my situation.

7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this process. 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.

8. I understand that Space Coast Psychiatry, Inc. will attempt to file claims to my current insurance plan. I agree to pay for all deductibles, co-insurances and co-pays resulting from insurance claims processing. If I am a private pay client, I agree to continue to pay for services at the current rate. I understand that if my insurance company denies payment for a claim, I will be responsible for the service at the current private pay rate.

9. I consent to my prescriptions being sent electronically to my pharmacy, unless discussed with my provider. I give consent to Space Coast Psychiatry, Inc. and its staff, to receive medication history records via electronic prescribing methods in order to assist with my treatment and care plan.

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.**

Client or Parent/Guardian Signature, If client is a minor: _____

Printed Name: _____ Date: _____