Turning Leaf Counseling

103 East State Street, Suite 301, Mason City, IA 50401
641-421-2089 *info@turningleafcounseling.com*

CONSENT TO PARTICIPATE IN TELEHEALTH

Name: _____Date of Birth:____-____-_____

Address:_____

City\State:_____,_____ Zip-Code:_____

Telephone:_____

Parent/Guardian:_____

There is an emerging worldwide illness, Coronovirus (COVID-19), that has made its way to the United States and to Iowa.

As we prepare for the possibility of COVID-19 infections in the North Iowa Area, we are considering telehealth (appointments through electronic media) instead of in-person appointments, in the event Turning Leaf Counseling cannot remain open for a period of time.

Telehealth would only be offered for a limited time in the event that widespread COVID-19 infections prevent our business from remaining open during quarantine or isolation periods. Once Turning Leaf Counseling returns to normal operation, telehealth would no longer be an option for appointments, including for patient illness during normal business hours.

PLEASE NOTE: Telephone conversation is not considered an appointment. It is not considered a replacement to in-person appointments. If you desire to continue seeing your provider while Turning Leaf is temporarily closed, telehealth is the only option.

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1. PURPOSE. The purpose of this form is to obtain your consent for a telehealth session with a therapist/prescriber.

2. NATURE OF TELEMENTAL HEALTH / TELEMEDICINE CONSULTATION. Telehealth involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. Utilizing telehealth services will require an Ipad/tablet, computer with a camera, and an internet connection.

3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telehealth include having access to therapist/prescriber and receiving therapy/prescriptions without having to travel to primary practice. A potential risk of telehealth is that equipment failure may result in the session not being. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. Not all insurances cover telehealth, this will be discussed individually depending on your policy.

4. MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telehealth shall not occur without your consent.

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5. CONFIDENTIALITY. All existing confidentiality protections under federal and Iowa law apply to information used or disclosed during your telehealth.

6. RIGHTS. You may withhold or withdraw your consent to telehealth at any time before and/or during the session without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telehealth.

7. By signing this document, I understand the circumstances under which telehealth services will be provided. You agree to see your therapist/provider by telehealth on a temporary basis and understand that telehealth services are a temporary service provided only under COVID-19 precautionary circumstances. I have received a copy of the explanation for provision of telehealth services.

_____ /_____		_____	_____
Signature	Date	Relationship to client	Expiration Date
_____/_____		_____	_____
Signature	Date	Relationship to client	Expiration Date

_____ /_____
Provider Signature Date

A photocopy of this signed Authorization shall have the same force and effect as this original