PLAZA WEST PSYCHIATRISTS

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Telehealth Patient Consent Form

Patient Name_____

DOB _____

Provider(s) Name _____

I agree to receive this health care service, as a telehealth service. I understand that the health care practitioner is located at Plaza West Psychiatrists 2222 S 16th St Ste 410 Lincoln NE 68502.

A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for the duration of treatment with Plaza West Psychiatrists.

I also understand that:

I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.

I may have to travel to see a health care practitioner in-person if I decline the telehealth service.

The same confidentiality protections that apply to my other medical care also apply to the telehealth service.

I will have access to all medical information resulting from the telehealth service as provided by law.

The information from the telehealth services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone without my additional written consent.

I will be informed of all people who will be present at all sites during my telehealth service.

I may exclude anyone from any site during my telehealth service.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient/Parent or Guardian _____Date: _____

Please email back to **plazawestpsych@aol.com**