

## **Consent to Participate in a Telehealth Consultation**

Patient Name: \_\_\_\_\_

### **1. Telemedicine**

Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications. I understand that my mental health care provider, wishes me to engage in a telemedicine consultation with Solace Counseling Associates.. This means that I and my health care provider or a designee will, through an interactive video connection, be able to consult with a designated healthcare practitioner about my condition.

### **2. Identity Verification**

You may be expected to provide a copy of your driver's license and other identity verifying documentation requested by the healthcare practitioner before any health services are provided.

### **3. Privacy and Security of Communications**

All electronic communications between you and the healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned healthcare practitioner when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session. You explicitly waive confidentiality if there is another individual at your distant site you are using telemedicine at.

### **4. Risks Associated with Distance Therapy**

There are privacy and security risks and consequences associated with telemedicine despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in telemedicine and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the Company to arrange a secure line of communication.

Telemedicine services and care may not be as effective as face-to-face services. The Company will continually assess the appropriateness of telemedicine for you. If the Company determines that you would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to you.

My health care provider has explained to me how the video conferencing technology will be used.

I understand that this consultation will not be the same as a face-to-face visit since I will not be in the same room as the healthcare practitioner, and that some parts of a visit may be conducted by individuals present with me at the direction of the healthcare practitioner. I also understand individuals may be present at either location to operate the audio/video equipment and that these individuals must maintain the confidentiality of health information disclosed, or if they join you at your discretion, then confidentiality may be waived.

I understand there are possible risks of an incomplete or ineffective consultation because of the technology, and that if any of the risks occur, the consultation may terminate. The risks may include:

- a. Failure, interruption or disconnection of the audio/video connection;
- b. A picture that is not clear enough to meet the needs of the consultation;
- c. A minor risk of access to the consultation through the interactive connection by electronic tampering.

I understand that in place of this telemedicine session I may seek face-to-face consultation with a health care provider.

I understand that I will not receive any royalties or other compensation for taking part in this telemedicine session or for the authorized use of any consultation images or audio.

I release Solace Counseling Associates, its employees, agents and assigns from any and all liability which may arise from this telemedicine consultation, the use of interactive audio/visual connections, or from the taking or authorized use of any images or audio obtained.

## **5. Communication Interruptions**

If you are unable to connect with the telemedicine platform or are disconnected during a session due to a technological breakdown, please try to reconnect within 5 minutes. If reconnection is not possible the Company can be reached at the following phone number: 612-584-1153.

## **6. E-Mail and Text Messages**

The undersigned healthcare practitioner may use and respond to e-mail and text messages only to arrange or modify appointments. Please do not send e-mails related to your treatment electronic communications are not completely secure and confidential. Any health related questions or issues will not be addressed by the healthcare practitioner in any electronic communication but will be dealt with during your next health session. Any electronic transmissions of information by you are retained in the logs of your service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. You should know that any e-mails or any communications sent via Facebook, online and specifically the Company website are not secure and you assume the risks of the insecure transmission.

**7. Audio and Video Recordings**

You acknowledge and, by signing this information and consent form below, agree that neither you nor the undersigned healthcare practitioner will record any part of your sessions unless you and the Company mutually agree in writing that the health session may be recorded. You further acknowledge that the Company objects to you recording any portion of your sessions without the Company’s written consent. You expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of your health records, and are therefore not protected by confidentiality or any other provisions under this agreement.

**8. Consent to Treatment Using Telemedicine and Distance Health Services**

I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the Company to provide such care, treatment, or services as are considered necessary and advisable. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

\_\_\_\_\_  
Patient/Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature if applicable