## Telehealth Consent

I hereby consent to participate in telehealth services with the providers at Arnold F. Negrin, MD Psychiatry, as part of my plan of care. I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider.

I agree to the following:

- I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit.
- I understand that I have the right to withhold or withdraw my consent for the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may also revoke my consent orally or in writing at any time by contacting the office of Arnold F. Negrin Psychiatry.
- I have been given the information regarding the use of Telehealth and consent to participate in services utilizing this technology.
- I understand that 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.
- I understand that the patient will be expected to have access to a two-way, real time interactive communication equipment. This includes audio and video communications designed to facilitate the delivery of services in a faced-to-face, interactive, though distant, engagement. This area should be safe, private, quiet, and free of distractions.
- I understand that the expectation for following the patient's plan of care is still expected, including but not limited to: appointment compliance, medication compliance, completion of requests for lab work, medical workups, psychological testing, and additional therapy services.
- I understand that the laws that protect the privacy and confidentiality of patient medical information also apply to telehealth services which include behavioral health unless an exception applies i.e. mandatory reporting of suspected abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding). As always, my insurance carrier will have access to medical records for quality review/audits.
- I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth health services are not appropriate and a higher level of care is required.
- For patient's receiving medications, the provider will require an updated list of medications, date of most recent menstrual cycle (if applicable), and access to scale to obtain the current weight. Medications that can be called into the pharmacy will be submitted to the preferred pharmacy on file.
- I understand that I am responsible for verifying the office has the correct mailing address, phone number, and insurance information on file.
- I understand that there are risks, benefits, and consequences associated with telehealth services, including but not limited to, disruption of transmission by technology failures, interruptions, and or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- I understand that for therapy services, the area should be quiet and private. That unless previously agreed upon, this is an individual session.
- I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please attempt to contact me at _____ to discuss, as we may have to reschedule.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Name: _____