TELEHEALTH POLICY
AND
INFORMED CONSENT FOR TELEHEALTH SERVICES

Patient Name:	Date of Birth:	Medical Record #:

Introduction:

The purpose of this Telehealth Services Policy and Consent Form is to explain to patients and their parents/guardians about the benefits and risks of telehealth services, inform them about their rights and confidentiality, and collect permissions from patients or their parents/guardians in order to participate into telehealth services.

Telehealth (aka: Telemedicine) 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 assessment, testing, diagnosis, consultation, treatment, therapy, follow-up and/or education, and may include, but not limited to: patient medical records, medical images, and live two-way audio and video. Telehealth provides an electronic delivery of healthcare services which does not require for patients and the clinicians to be in the same physical location (i.e. doctor's office). Through the video call technology, telehealth practice/treatment is provided by healthcare practitioners, psychiatrists, nurse practitioners, licensed clinical social workers, other specialists and professionals. Interactive appointments are held via teleconference/video call platform that includes audio and video support communications.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home or at a remote site while the clinician is at his/her office or remote site.
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist

Possible Risks:

As with any electronic technology, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images/video image) to allow for appropriate medical/clinical decision making by the clinician;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment, mobile devices, computers and internet connection;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error

Confidentiality:

All existing confidentiality protections under federal and state law apply to information used or disclosed during your telehealth session. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where the patient makes his/her mental or emotional state an issue in a legal proceeding. Your insurance carrier will have access to telehealth medical records along with your other medical records by your clinician for quality review/audits.

Patient Rights:

Patients can withdraw or withhold this consent at any time. Any action will not affect the future treatment of patients. Patients can ask any question regarding telehealth services, treatment process, and appointments before, during, or after the treatment.

Payment:

Patients accept they are responsible for additional charges that may occur with the use of telehealth or co-payments that their insurance carriers do not cover. Generally, telehealth is considered by most insurance companies to be same co-pay/coinsurance as an in office appointment. Ultimately, it is the patient responsibility to contact their insurance carrier to inquire about telehealth/telemedicine benefit coverage; and if any authorization is required for such services.

PATIENT CONSENT TO THE USE OF TELEHEALTH SERVICES

By signing this form, I attest to and understand the following:

- I have been given Cornerstone Psychiatric Services, Inc. Telehealth Policy regarding the use of telehealth and consent to participate in services utilizing this technology.
- I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver service to an individual when he/she is located at a different site than the clinician. Telehealth may involve the communication of my mental health information, both orally and visually.
- I attest that I am located in the state of Florida and will be present in the state of Florida during all telehealth sessions with my clinician.
- I understand that the laws that protect privacy and the confidentiality of my protected health information (PHI) also apply to telehealth service unless an exception to confidentiality applies as stated in our Telehealth Policy.
- 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 it is my responsibility to ensure privacy and security of communication to wherever I am located and however I am utilizing the service; I understand that it is my responsibility to secure my device. Any breach or problem that may arise through my device such as computer, tablet, or mobile phone shall be my (patient) full responsibility.
- I understand that there are benefits, risks, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. If such disruption of transmission occurs, the session will be attempted again by your clinician. If unable to re-connect or complete a telehealth session determined by your clinician, then you agree that the telehealth session will be re-scheduled or you may be offered an in office appointment.
- I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My clinician or Cornerstone office staff has explained the alternatives to my satisfaction.
- I understand that the clinician is not responsible for any technological difficulties that may arise and he or she has no control over such matter.
- 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 services are not appropriate and a higher level of care is required.
- I understand that the telehealth service is not an emergency service. In case of emergency, I shall contact 9-1-1 or any other emergency service provided by local authorities or institutions/hospitals.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that my clinician and/or office staff at Cornerstone Psychiatric Services may need to contact my emergency contact and/or appropriate authorities in case of an emergency during a telehealth session.

Emergency Protocols:

We need to know your location in case of an emergency. You agree to inform us, if asked, of the address/location of where you are at during each telehealth session. We also need a contact person who we may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact name: _____ and Phone number:_____

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician or Cornerstone office staff as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth/telemedicine in my medical care. This consent is valid for the duration of my treatment at Cornerstone Psychiatric, unless revoked by me or the Cornerstone Psychiatric clinician.

I hereby authorize my treating clinician to use telehealth in the course of my diagnosis and treatment; and agree to participate.

Signature of Patient (or person authorized to sign for patient): _____

If authorized signer, relationship to patient: _____ Date: _____