Pike Creek Psychological Center

CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

Patient Name: _____ DOB: _____ Clinician: _____

1. I understand that my treating clinician affiliated with Pike Creek Psychological Center is available and offering to engage in telemedicine services for those who can be served in this manner. 1 further understand that the treating clinician will assess my case specifically to determine the safety and appropriateness of distance services, and reserves the right to decline provision of such services.
2. My care provider has explained to me how two-way video and voice technology will be used to securely host the session, including how to access the secure service. 1 understand that this service will be different from in-person sessions due to the fact that **I** will not be in the same room as the clinician. I acknowledge that I have access to technology that meets the requirements of the program used to host the session.
3. The program used will be HIPAA HITECH compatible. However, it is understood that electronic means of communication are susceptible to certain risks. White everything will be done to minimize this risk, I understand the potential for complications, including interruptions, technical difficulties, and the potential for unauthorized access.
4. 1 understand that my healthcare information will be shared with others who are held to the same standard of confidentiality, for the purposes of scheduling and billing, and in the same manner as an office visit.
5. Those present during the session will he held to the same expectation of confidentiality as those present during an in-person office visit. It is understood that it **is the patient's responsibility to ensure privacy and confidentiality in the space in which they choose to engage in the session.** In the rare event that another person may be present in the therapy office at the time of the appointment, the clinician initiating the session will immediately inform the patient in the same manner that would occur if the session were occurring in-person, and the patient has the right to decline or terminate the session.
6. 1 have received an explanation of alternate methods of engaging in sessions and have accepted the telemedicine service freely and of my own choosing. I understand that I have the right to decline participation in this service and can end my participation in telemedicine services at any time by informing my clinician in advance of any future appointments.
7. I understand that billing will occur according to the requirements set forth by my insurance company and the telemedicine laws defined in the state of Delaware. There is no guarantee that my insurance will pay for telehealth sessions, but if appropriate, a claim will be submitted. If the claim is not paid by insurance, I understand that I am responsible for the cost of the session. I will provide a credit card number to be kept on file for co-pays, deductibles and the cost of the session if it is not paid for by my insurance.
8. **I understand that I must be physically present in the state agreed upon with my therapist.** By initiating telemedicine sessions, I am acknowledging my commitment and responsibility to remain in the state during the entirety of the Session.
9. 1 understand that the same limits of confidentiality and requirements for mandated reporting are upheld during and resulting from telemedicine sessions. A crisis plan will be set forth prior to participating in a telemedicine session.

My signature below indicates that I have read this document carefully and understand the risks and benefits of the telemedicine appointment and have had my questions regarding the procedure explained. 1 hereby consent to participate in telemedicine visits under the terms described herein.

_____ _____

Patient / Parent Guardian Signature Date