Pike Creek Psychological Center

CONSENT TO PARTICIPATE IN THE TELEMEDICINE SERVICE

(In State)

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. I 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. I understand that this service will be different from in-person sessions due to the fact 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 HIPPA HITECH compatible. However, it is understood that electronic means of communication are susceptible to certain risks. While 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. I 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 be 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 endure 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. I 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 the 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 sate of Delaware.

8. **I understand that I must be physically present in the state of Delaware where the clinician holds active license to practice.** By initiating telemedicine sessions, I am acknowledging my commitment and responsibility to remain in the state during the entirety of the session.

9. I 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. I also acknowledge that I have access to technology that meets the requirements of the program used by the clinician. I hereby consent to participate in telemedicine visits under the terms described herein.

_____ _____

Patient / Parent / Guardian Signature Date

_____ _____

Witness Signature Date