Advocates for Reproductive Education

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WeARE Consent to Telehealth Services

Telehealth is the delivery of health care services (medical, psychiatric, therapeutic, dental) using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

I consent for_____(patient name) to engage in telehealth services with WeARE-The Clinic. I understand and agree to the following for the duration of telehealth services with WeARE-The Clinic:

1. I have the right to withhold or remove consent for telehealth services at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is confidential, just as it would be if I were in the clinic. I understand that mandated reporting laws will be followed by my provider during telehealth visits.

3. I understand that telehealth visits are transmitted via HIPAA approved platforms and that providers will take all reasonable measures to ensure that privacy is maintained during telehealth appointments. It is my responsibility to ensure that I access the internet through secure means and that I am in a private location to conduct my session to maintain privacy.

4. I understand that certain situations including emergencies and crises are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.

5. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

6. I understand that telehealth based services and care may not be as complete as face-to-face services and that not all therapeutic interventions, services or patients are appropriate for telehealth services. I also understand that if my provider believes I would be better served by another form of services (e.g. face-to-face services) I will be asked to physically come to WeARE-The Clinic for a face-to-face visit or referred to a provider who can provide such services in my area.

7. I understand that a lack of access to all the information that might be available in a face to face visit, but not in a telehealth session, may result in errors in judgment. Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.

8. I understand that a limited examination may take place during the videoconference and that lab and other tests are not available via telehealth.

9. I have the right to ask my healthcare provider to discontinue the conference at any time.

10. I understand that no part of the telehealth visit will be recorded by my provider and agree not to record any part of the visit myself.

11. I understand that my provider will document in my medical chart as if the visit were conducted in person with only the additional information required for telehealth billing.

12. I understand that I, or my insurance, will be billed as authorized by my insurance and/or sliding fee plan.

I hereby consent to engaging in telehealth with WeARE The-Clinic as part of my healthcare evaluation and treatment. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read this document and understand the risk and benefits of the telehealth services. This consent shall remain in effect for one year after the date you sign it unless you enter a different date or expiration here:_____. This consent may be revoked verbally or in writing at any time.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient (or Parent/Guardian) Printed name of Parent/Guardian