Human Dynamics & Diagnostics, LLC

2267 Teton Plaza, Idaho Falls, ID 83404
Phone: 208-522-0140 Fax: 208-524-7335

The purpose of this questionnaire is to obtain a comprehensive picture of you or your child's mental health background. In treatment, records are necessary to provide a high quality of services. By completing these questions, as fully and accurately as possible, it will help to ensure the highest quality of care. All case records are kept confidential – **No one outside of this clinic will be permitted to see these records without your written permission.** If you do not desire to answer a particular question, please just state "Do Not Care to Answer." If not applicable, please state N/A.

***PLEASE FILL OUT WITH BLACK OR DARK BLUE INK ONLY.**

**** THESE FORMS MUST BE FILLED OUT COMPLETELY PRIOR TO THE FIRST APPOINTMENT.**

Patient Name:		Date:
Preferred name/nickname:		
Address:		
City:	State:	ZIP Code:
Phone (home):	Phone (cell):	
Phone (work):	Phone (other):	
S.S. #:	Date of Birth:	
Age:	Gender: ☐Male ☐Female	
Marital Status: ☐Single ☐Married ☐Cohabitating ☐Separated ☐Divorced ☐Widowed		
Occupation:	Employer:	
Date of last Physical:	**Name of Physician:**	
Whom may we thank for referring you?		
Emergency Contact:	Phone:	
FOR CHILD CLIENTS ONLY:		
Primary Guardian:	Relationship to client:	
Phone:	Address:	

RESPONSIBLE PARTY FOR AUTHORIZATION OF MEDICAL TREATMENT

Name____ S.S. #______________________________________

Address____Phone_______________________

City____State______________________Zip______________________

Sex: M☐ F☐ Age______ Birthdate_____/_____/_____ Single Married Widowed Divorced Separated

Employed By____Occupation___________________________________

Work Address____Work Phone______________________________

PRIMARY INSURANCE

Insured Name____ S.S. #_____________________________________

Relation to Patient_____________________________________

Address____Phone_______________________

City____State______________________Zip______________________

Sex: M☐ F☐ Age______ Birthdate_____/_____/_____ Single Married Widowed Divorced Separated

Employed By____Occupation___________________________________

Insurance Company_________________________________I.D. #______________________Group #_______________

ADDITIONAL INSURANCE

Is patient insured by additional insurance? ☐Yes ☐No

Insured Name____ S.S. #_____________________________________

Relation to Patient_____________________________________

Address____Phone_______________________

City____State______________________Zip______________________

Sex: M☐ F☐ Age______ Birthdate_____/_____/_____ Single Married Widowed Divorced Separated

Employed By____Occupation___________________________________

Insurance Company_________________________________I.D. #______________________Group #_______________

Please check whether you are covered by the following:

Medicare ☐ YES ☐ NO **Medicaid YES program** ☐ YES ☐ NO **Medicaid** ☐ YES ☐ NO

Responsible Party Signature: ____ Date: ____________________________

Relationship to Patient: ____

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FINANCIAL POLICY AND CONTRACT FOR SERVICES

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of our care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

- With the exception of Medicaid patients, **payment is expected once per month** unless alternative financial arrangements have been made in advance.
- Private-pay Community Based Rehabilitation Services are $50/hr.
- **All forms of insurance must be reported to the billing office.** If you fail to provide copies of your insurance information or notify HDD of changes you will be charged a $50 reprocessing fee.
- If your outstanding balance reaches **$200** you will be contacted by our billing office and future services may be suspended until the balance is paid in full or a reasonable payment arrangement is reached.
- We assist all of our patients with their financial needs by preparing and forwarding insurance claim forms. We are willing to work with you regarding payments for the services provided. We do charge an interest fee of 1.5% for all accounts over 90 days past due. If payments are not received on a monthly basis for the amounts agreed upon the account can and will be assigned to an outside collection agency. In this event, you will be charged a $25 collection fee.
- If at least 90 days have passed from receipt of the final statement by the patient and final resolution of all internal reviews, good faith disputes, and appeals of any charges or third-party payor obligations or payments, and a payment has not been received, the account will be reported to collections. Human Dynamics & Diagnostics will use North American Collections, 1393 Cambridge Dr. Idaho Falls, Idaho 83401 208-522-8013 for all collection issues. *Title 48, Chapter 3, section 48-304 Requirements for Extraordinary Collection Action (5)* https://legislature.idaho.gov/statutesrules/idstat/Title48/T48CH3/
- **I understand that regardless of insurance coverage, I am responsible for all charges and payments.**
- **MINOR PATIENTS**: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

I authorize **Human Dynamics & Diagnostics, LLC** to receive assignment of insurance payments. **Human Dynamics & Diagnostics, LLC** is hereby authorized to release medical information to my health insurance company that may be necessary for processing of claims.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Responsible Party Signature	Relationship to Patient	Date

Human Dynamics & Diagnostics, LLC

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PATIENT INFORMATION AND CONSENT

APPOINTMENTS: Office visits are by appointment only. When you call for an initial appointment, our Office Manager will ask a few questions regarding the nature and urgency of your concern or problems.

CANCELLATIONS: We request that cancellations be made **at least 24 hours in advance** of scheduled appointments or **you will be charged a late cancel fee up to the amount charged by the clinician you are seeing. The fee may be as small as 32.50 but up to 125.00.** It is your responsibility to keep appointment you make. Human Dynamics has a waiting list at all times and will make every effort to fill appointments cancelled less than 24hr in advance. If we do fill the appointment, you will not be charged for the late cancel fee.

TIMES: Appointments take approximately forty-five to fifty minutes.

FEES, BILLING AND INSURANCE: Insurance information will be gathered and assessed prior to the appointment. Fees vary according to the type of appointment and services. Co-payments are expected at the time of service. You are responsible for all fees for services delivered, although other persons or insurance companies may make payments on your account. There is a $20.00 charge for all returned checks.

CONFIDENTIALITY: The information discussed during your appointment is confidential. That is, it cannot be shared with others unless permission is granted by you. If you wish to have us communicate information to others, we will ask you to sign a "Consent to Release Information" form.

Limited confidential information can be released by the Clinic without your consent in extraordinary situations involving: (1) suspected neglect or abuse of a child, or (2) life threatening danger to you or others, as in cases of very high suicide risk or threats of bodily harm against others, (3) if so ordered by a court or required by applicable law.

EMERGENCY AND AFTER HOURS COVERAGE: If an emergency arises after business hours, you can either call the crisis service at The Behavioral Health Center at (208) 227-2260 (24 hours/day) or the crisis service at the Region VII Mental Health Office at (208) 528-5717 (24 hours/day). You may also proceed directly to the Emergency Room at Eastern Idaho Regional Medical Center.

NON-COMPLIANCE/NON-PAYMENT OF SERVICES: Human Dynamics & Diagnostics may exercise the right to terminate the provision of services if clients are non-compliant with treatment or for non-payment of services rendered (see financial policy).

I understand the nature and purpose of this Clinic and understand that no promises have been made to me as to the results of treatment provided. I acknowledge that this consent has explained the proposed care in a satisfactory manner and that all questions asked about the care and its attendant risks have been answered in a manner satisfactory to me.

________________________________ ____________________
Responsible Party Signature Date

____
Relationship to Patient

Human Dynamics & Diagnostics, LLC

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CONSENT FOR TREATMENT

SERVICES: Mental Health services adhere to the current standard of care both in the Idaho Falls area and on a national level. There is no guarantee that any service or medication provided will alleviate completely the symptoms addressed. Services provided will be: Medication Management, Counseling, Developmental Disability Services, and Family/Peer Supports. Risks associated with these services include a worsening of your condition, alternatives include seeking or not seeking other forms of counseling or psychotherapy and the purpose and benefits include a possible improvement of your condition. Services are limited because of third party/Medicaid payer requirements and may be modified or ended due to payer policies. Third parties are billed based upon our fee schedule. Billing is performed at no cost to clients. I also understand that I have a right to select my service provider, refuse these services and withdraw this consent at any time.

I (patient or if child, parent) ____ understand the above.

CONFIDENTIALITY: We will make every attempt to keep your records private in this office. The exceptions to this are that we will send reports to your referring physician/therapist for coordination of care. You must tell us otherwise if you do not desire communication between clinicians. You must also be aware that your insurance company may request clinical summaries to authorize continued care. They may also visit this office and view your entire record. This is part of the contract we must sign to be providers in their network and you sign to receive benefits. Human Dynamics and Diagnostics, L.L.C. will not release any records without your written consent. **However, by signing this agreement, you do allow each sector of this clinic to speak to another about your care; i.e. your Counselor can speak to your psychiatrist by signing this Consent for Treatment.** In addition, we will not be able to provide any information about patient care to parties calling on the phone without written consent and identification of the party prior to telephone contact. Your insurance claims will be submitted electronically or mailed with diagnostic code and a code for type of service rendered.

A Copy of this Agreement is Available upon Your Request
This agreement is good for 14 months from date of signature

____ _____________________________________

Responsible Party Signature Date

____

Relationship to Patient

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STATEMENT OF PATIENT'S RIGHTS, RESPONSIBILITIES, AND GRIEVANCE PROCESS

As a client or guardian of client receiving mental health services from Human Dynamics and Diagnostics, LLC you have the following rights

Professional Expertise: Clients or their guardian have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Clients or their guardian have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

HIPAA Privacy and Security: As detailed in Human Dynamics Notice of Privacy Practices and Confidentiality Statement, clients or their guardian have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care. Information technology will be used for transmission, storage, or data management only with methodologies that assure the protection of the client's privacy. Information shall not be transferred, sold, or otherwise utilized.

Choice and Consent: Clients or their guardian have the right to choose any duly licensed/certified professional for mental health and substance abuse services and consent to treatment. Clients or their guardian have the right to receive full information regarding the education and training of professionals, treatment options (including risks, benefits and alternatives), and cost implications to make an informed choice regarding the selection of care deemed appropriate by client and professional. Clients or their guardians also have the right to refuse treatment and withdraw consent for treatment.

Determination of Treatment: Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the client and his or her family as appropriate. Treatment decisions should not be made by third party payers. The client or their guardian has the right to make final decisions regarding treatment.

Nondiscrimination: Quality mental health services shall be provided to all clients without regard to race, color, religion, national origin, gender, age, sexual orientation, or disability.

Contractual Limitations: Clients or their guardian have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between the third-party payer and the treating professional that could interfere with or influence treatment recommendations. Clients or their guardian have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

Treatment Review: To assure that treatment review processes are fair and valid, Clients or their guardian have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials, and licensure required to provide the treatment in the jurisdiction in which it will be provided

Accountability: Treating professionals may be held accountable and liable to clients or their guardian for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the client of options if payment authorization is denied.

Complaints and Grievances: Clients or their guardian have the right to submit complaints or grievances regarding provision of care by the treating professional to the owner of Human Dynamics and Diagnostics, LLC, as well as Human Dynamic's regulatory agencies.

- If a client feels he or she has a complaint against the agency, he/she will be encouraged to make their complaint in writing to the owner of the agency.
- A written response will be generated and kept as part of the client's record in his/her chart for two years.
- If the matter cannot be successfully reconciled, the client will be encouraged to take the complaint to the Optum Idaho. **Member Toll-Free** (855) 202-0973.

As a client or guardian of client receiving mental health services from Human Dynamics & Diagnostics, LLC you also have the following responsibilities:

- **Participation** – You have the responsibility to participate actively and honestly in your or your loved one's treatment.
- **Engagement** – You are responsible for asking questions about any policy, procedure or treatment which you do not understand or with which you do not agree.
- **Respect** – You have the responsibility to treat HDD personnel and clients with dignity and respect**.**
- **Informed Consent** – You are responsible for carefully reading and understanding any papers you may be asked to sign in relation to your or your loved one's treatment.

Signature for acknowledgement of Patient's Rights, Responsibilities, and Grievance Policy

______________________________	______________________________
Patient Name	Relationship to Patient
______________________________	______________________________
Responsible Party Signature	Date

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NOTICE OF PRIVACY PRACTICES (NPP)

PATIENT ACKNOWLEDGEMENT

Date: ______________________________

I acknowledge that I was provided with a copy of the Human Dynamics & Diagnostics Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

Name of Patient (Please Print):____

Name of Patient (Signature):____________________________________ Date: ______________________

Note: If the Notice of Privacy Practices (NPP) Patient Acknowledgement form is being completed by a patient's personal representative or guardian, please print and sign your name in the space below:

Name of Patient representative (Please Print): ____

Name of Patient representative (Signature): ______________________________ Date: __________________

FOR INTERNAL USE ONLY

Please complete this section ONLY if this form is not signed and dated by the patient or patient's personal representative.

I made a good faith effort to obtain a written acknowledgement of receipt of Human Dynamics & Diagnostic's Notice of Privacy Practices but was unable to for one of the following four (4) reasons:

☐ Patient refused to sign the form.

☐Patient was unable to sign the form.

☐Patient forgot to sign the form.

☐Other: ____

Employee Name: ____________________________________ Title: ____________________________

Date: ________________________________

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STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Human Dynamics and Diagnostics LLC

I.) INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name:____ Date of Birth:______________________________

Address:______________________________________ City:____________________ State:____________

Telephone Number:____ Zip:____________

II.) SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow **Human Dynamics and Diagnostics** to share my protected health information as set forth below, for reasons in addition to those already permitted by law.

A. Person/Organization Receiving Information and Purpose for Sharing

Persons/Organizations Authorized to Receive My Information

(Name, Address, Phone & Fax)	Relationship	Purpose

B. Information to be shared

1. Check one or more boxes below.

☐ Entire Medical Record (includes all records except Psychotherapy Notes)
☐ Psychotherapy Notes (if checking this box. no other boxes may be checked)
☐ Mental Health Records
☐ Alcohol or Drug Abuse Records
☐ HIV Records
☐ STD Records
☐ Progress Notes
☐ Medical Images
☐ Radiology Report(s)
☐ Cardiology Report(s)
☐ History and Physical
☐ Operation Reports
☐ Consultation Report(s)
☐ Pathology Reports
☐ Discharge Summary
☐ Physician's Orders
☐ Laboratory Report(s)
☐Other:____

2. Covering Services Between __________________ and __________________ (Insert either date(s) or "all.")

III. EXPIRATION & REVOCATION

A. This Authorization will Expire (must choose one):

☐12 months from the date signed in Part IV.B. ☐Other (insert date or event):_________________________

B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization. This form may be voided and a new one in place at the discretion of Human Dynamics.

IV. ACKNOLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

B. Signature

This document must be signed by the individual or the individual's legal representative.

____

Signature (Patient or Legal Representative) Date

____

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

Address of entity authorized to release information:

Human Dynamics and Diagnostics LLC
2267 Teton Plaza
Idaho Falls, ID 83404

____

The following information is for administrative purposes and may only be completed by an entity that is a "Program" under 42 C.F. R. Part 2 with respect to alcohol and drug abuse

42 C. F.R. Part 2:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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PATIENT EMAIL AND TEXT

Important Information & Disclosure

As a patient of Human Dynamics & Diagnostics you may request that our organization communicate with you by electronic mail (email) and/or text message. As such, this Patient Email Sheet will inform you about the risks of communicating with your health care provider, or any other organization, via email and/or text message and how Human Dynamics & Diagnostics will use and disclose provider / patient email and/or text message.

Please read carefully

- Email and text communications is an effective a protocol for two-way communications. However, responses and replies to emails and texts sent to or received by either you or any other party may be hours or even days apart.

- This means that there could be a significant delay in receiving treatment for one's condition.
  Therefore, if you have an urgent medical emergency situation, you should not rely solely on email and/ or text with our organization for purposes of requesting assistance or to describe the urgent or emergency situation.

- Email messages on your computer, laptop, or other electronic medium or device have numerous privacy risks, particularly when your email access is provided through an employer or when access to your email messages is not password protected. If an email is not sent with secured technologies, such as encryption, the email (specifically, all of its contents) can be easily compromised in today's cyber world.

- Text messages on your phone, computer, laptop, or other electronic medium or device have numerous privacy risks, particularly when your device is not password protected.

- Unencrypted email and text provide as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is sent through the Post Office.

- Email and text is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled.

- Errors in transmission, regardless of the sender's caution, can occur. You can also help minimize this risk by using only the email address or phone number that you provide to our practice/program/provider.

- In order to forward or to process and respond to your email and text, individuals at Human Dynamics & Diagnostics other than your health care provider may read your email message. Your email and text message is not private communication between you and your treating provider.

- Neither you nor the person reading your email and text can see the facial expressions or gestures or hear the voice of the sender. Email and text can be misinterpreted.

- At your health care provider's discretion, your email and/or text message and any and all responses to them may become part of your medical record.

PATIENT REQUEST FOR EMAIL AND TEXT COMMUNICATIONS

Important Information & Disclosure

Name of Patient: ______________________________________ **Phone Number:** ____________________________

Email Address: ____

Please read carefully

Communications over the Internet and/or using the email system and/or text message may not be encrypted and therefore, may not be secure. Because of this, there is no assurance of confidentiality, integrity, and availability (CIA) of the communication itself. Today's growing cyber security threats and challenges mean that at any given time, your communication – if not protected by encryption – can be compromised. If you are fully aware of this and still wish to have Human Dynamics & Diagnostics communicate with you via email and/or text message, please complete this form and return it Human Dynamics & Diagnostics in a timely manner.

Additionally, please be advised of the following:

This request for email communication and text message of Protected Health Information (PHI) only applies to Human Dynamics & Diagnostics. If you would like to request to communicate via email or text message with another health care provider or program, then you must complete a separate request for such office.

Human Dynamics & Diagnostics will not, under any circumstances, communicate certain health information that is specifically protected under state and federal law.

I understand and agree to the following:

- I certify that the email address and phone number provided to Human Dynamics & Diagnostics on this request is accurate, and that I accept full responsibility for messages sent to and from this address/phone number.
- I completely understand, am well aware and acknowledge that communication over the Internet and/or using any type of email or text protocol may not be encrypted, thus it may not be secure.
- I agree to hold Human Dynamics & Diagnostics and other organizations and individuals associated with such communication harmless from any and all claims and liabilities arising from or related to this request to communicate via email and/or text.

____ _______________________________________

Patient Name | Relationship to Patient

____ _______________________________________

Responsible Party Signature | Date

HUMAN DYNAMICS & DIAGNOSTICS

2267 Teton Plaza, Idaho Falls, ID 83404
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www.humandynamicsid.com

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Provider is defined as LCSW, LMSW, LPC, LCPC, LMFT, MD, PA-C, and community-based staff duly licensed/credentialled and employed by or contracted with Human Dynamics and Diagnostics LLC.

- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. The platform used by providers will be HIPAA compliant such as doxy.me or Zoom medical edition. Non-secure platforms such as Apple's Facetime will not be used. Only under declared "Emergency status by local or state governments will be the exception to this provision".

- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office. Likewise, my Provider may opt-out at any time.

- I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of **IDAHO** at the time of this service. Likewise, my Provider will be in the state of Idaho.

- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and **it is my responsibility to check with my insurance plan to determine coverage.**

- **I understand that Human Dynamics charges a technology fee for each telehealth session of $20.00, if non-covered by insurance**. This fee is to help cover the costs of the telehealth platform, equipment and maintenance of the service.

- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
  - *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
  - *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
  - *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose/treat a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing and request for an in-person visit.
- I understand that electronic communication may be used to communicate highly sensitive medical information related to mental health treatment.
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

Patient Consent to the use of Telehealth
I have read and understand the information provided above regarding telepsychiatry, have discussed it with Provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care and authorize Provider, to use telemedicine in the course of my diagnosis and treatment.

For electronic communication between

Healthcare Providers at Human Dynamics and Diagnostics and ______________________________

(Print Agency or Provider's name) *(Print Patient's name)*

______________________________ ______________________________

Patient or Legal Representative Signature Date

______________________________ ______________________________

Print Patient or Legal Representative Name Relationship to Patient