HUMAN DYNAMICS & DIAGNOSTICS

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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