CONSENT FOR TELEHEALTH VIDEO VISITS

What is Telehealth?

Telehealth is healthcare provided by any means other than a face-to-face visit. In Telehealth services, nursing, 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/or remote patient monitoring are all considered Telehealth services.

I hereby consent to participate in Telehealth with, Dr. Jennifer Muhammad, DNP, NP-BC a Family & Psychiatric Nurse Practitioner, Healthy Wings LLC, Healthy Wings Family & Psychiatric Healthcare, its employees, contractors and/or assigns, as part of my care.

I understand that Telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two separate locations.

I understand the following with respect to psychiatric and/or mental Telehealth:

- I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- There are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- The privacy laws that protect the confidentiality of my protected health information (PHI) also apply to psychiatric and/or mental Telehealth unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or I raise mental/emotional health as an issue in a legal proceeding).
- If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth services are not appropriate, and a higher level of care is required.
- Electronic communication may be used to communicate extremely sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- During a Telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, please immediately end the session, and restart the session. If we are unable to reconnect within five (5) minutes, please telephone me at (520) 477-1815 to discuss since we may have to re-schedule.
- I understand my provider(s) and/or their staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
- **Electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made DIRECTLY to the provider's office at (520) 477-1815, or to the existing emergency 911 services in my community especially if after regularly scheduled office hours.**

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a Telehealth visit.

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 and/or psychiatric mental health care is provided.

To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution, practice, and/or assigns from any claims I may have about the Telehealth visit.

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

Patient's/Representative's Signature: _____ Today's Date: _____

Print Representative's Name: _____

Print Mailing Address: _____

If signed by anyone other than the patient, indicate the relationship to the patient: ____ Parent ____ Guardian ____ Agent

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