Outreach
Teen & Family Services, Inc.
Counseling. Care. Connection.

TELEMEDICINE INFORMED CONSENT

I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners within the agency.

My signature below denotes my consent & understanding:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal services to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my counseling is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where my mental or emotional state an issue in a legal proceeding.

(3) I understand the risks associated with telemedicine, including, but not limited to: the possibility, despite reasonable efforts, that transmission of my medical information could be disrupted or distorted by technical failures; unauthorized persons could interrupt transmission of my medical information. Additionally, telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my counselor believes I would be better served by face-to-face services I will be referred to a counselor who can provide such services in my area or I will postpone my treatment until a time when face to face sessions can begin again.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Pennsylvania law.

(6) In an effort to recognize that telemedicine can be interrupted by Wi-Fi/internet access my counselor and I have decided that if the internet is not available, a phone call could be utilized during the appointment time until internet access resumes for either of us. I understand that my counselor may call me from an undisclosed, blocked or anonymous number.

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In case of an emergency, my counselor has my consent to contact:

_____ _____

Emergency Contact Name Emergency Contact Phone

My primary contact number for telemedicine sessions is:

_____

I understand that I am still responsible for all deductible/co-pay amounts/fees associated with my fees for services regardless of in person, phone or video session format.

I have read and understand the information provided above. I have discussed it with my counselor, and all of my questions have been answered to my satisfaction. My signature below denotes my informed consent.

_____

Signature of client and/or guardian Date

_____

Signature of counselor Date

**If a crisis occurs, I agree to utilize the local crisis hotline where I am located and I acknowledge that my counselor has my consent to do that on my behalf if deemed necessary.*
The local crisis hotline is RESOLVE Crisis Services: (888) 796-8226