



**INTRODUCTION**

Telemedicine involves the use of electronic communications to enable Dayspring providers to connect with individual patients using interactive video and audio communications.

Telehealth includes the practice of primary care and mental health care consultation, delivery, diagnoses, treatment, education, referrals, and the transfer of medical and clinical data.

I understand that I have the right with respects to telehealth services:

* The laws that protect the confidentiality of my personal information also apply to telehealth. I understand that the information disclosed by me during the course of my telehealth services 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 toward an individual/victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth services to other entities shall not occur without my written permission.
* I have the right to withhold or withdraw my consent to the use of telehealth services in the course of my care at any time without affecting my right to future care or treatment.
* There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider and Dayspring Health that:
  + The transmission of my personal information could be disrupted or distorted by technical failures
  + The transmission of my personal information could be interrupted by unauthorized persons
* I understand that if my provider believes I would be better served by another form of intervention, then I will be referred to another appropriate provider (such as, emergency department, local clinic or another mental health professional) I also understand that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
* The alternatives to telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using phone or video technology.
* I also understand that at my request or at the direction of my provider as the circumstances change, services will resume as “face-to-face” medical care or psychotherapy.
* I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
* That my healthcare information may be shared with other individuals for scheduling and billing purposes
* I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.
* By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based assessment and treatment. If I am in crisis or an emergency, I should call 9-1-1 immediately or seek help from a hospital or crisis-oriented health care facility in my immediate area.
* I understand that different states have different regulations for the use of telehealth.

**PAYMENT FOR TELEHEALTH SERVICES**

Dayspring Health will bill insurance for telehealth services when these services have been determined to be covered by an individual’s insurance plan. Standard insurance co-pay rates will be applied. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage we will follow standard practices, including offer of sliding scale discount benefit.

**PATIENT CONSENT TO THE USE OF TELEHEALTH**

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agreed to the terms of this document.

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| --- | --- |
|  |  |
| Patient’s Name (printed) |  |
|  |  |
| Patient or Legal Guardian’s Signature | Date |

**INFORMED CONSENT FOR TELEHEALTH SERVICES**

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