Telehealth/Telemedicine Release

Therapist: Laurel Eby, M.Ed., LMHC **License Number:** LH60889526

Client's Name: _____

1. I understand that my counselor wishes me to engage in a telemedicine consultation.
2. My counselor has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/ provider visit due to the fact that I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above mentioned people will all maintain confidentiality of the information obtained.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.
6. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that I have read or had this form read and/or had this form explained to me; that I fully understand its contents including the risks and benefits of the consultation; that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient/parent/guardian signature Date