INFORMED CONSENT FOR TELEHEALTH SERVICES

Purpose

Genesis Family Health (GFH) and the healthcare provider assigned to me today will provide healthcare services through the use of live, two-way video (visual) and/or audio (sound), and other computer-based services. This type of care is often referred to as "telehealth" or "telemedicine." Telehealth services allow the provider to obtain information about health status through electronic communications for the purpose of diagnosing and determining a treatment plan for certain non-emergency conditions. The information provided or exchanged may be used for diagnosis; treatment plan development and review; and case management; and may include any or all of the following electronic communications: patient medical record documentation, live two-way video and audio files, transmission of images, and/or other data.

Possible Risks

As with any use of technology, there are potential risks associated with telehealth services. I understand that these risks include, but may not be limited to, the following:

- Delays or errors in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Information transmitted may not be sufficient to allow for appropriate medical decision-making.
- Although precautions are taken to protect the confidentiality of information, new security threats can develop.
- There may be other risks to the confidentiality and security of my personal information that neither GFH nor I can anticipate at this time.

Patient Consent

- I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I am not required to use telehealth services; it is my choice to do so.
- I understand that the provider of my telehealth services will record information about the services I receive in my GFH electronic medical record.
- I understand that no results can be guaranteed or assured.
- I understand that I will be charged for telehealth services by a GFH provider. If I have insurance and/or other third-party coverage such as Medicare or Medicaid, I understand telehealth services may not be covered. If my insurance and/or other third-party coverage does not pay for telehealth services, I understand that I am financially responsible.
- I understand that the provider may terminate a telehealth visit if he/she determines that my condition requires immediate in-person care, or otherwise determines that a telehealth visit is not appropriate to meet my healthcare needs.
- I understand that my medical information may be sent to other healthcare providers as part of coordination of care.
- I understand that providers may not prescribe certain types of medicines, including controlled substances, based solely on a telehealth visit.
- I understand and agree that any prescriptions I receive from a telehealth visit are to be used only by me as intended for my healthcare needs.

I have read this document carefully, understand the risks and benefits, and wish to obtain telehealth services.

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Signature of Patient/Parent/Guardian Date

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Patient's Full Name Date of Birth