Sylva Clinical- *PSYCHOLOGY!*

Breathe in. Breathe out. Relax...

JERRY COFFEY, PH.D.
Child/School Psychology

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General Psychology

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Adolescent/Adult Counseling

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LAUREN J MARCH, PSYD, LCAS
Child/Adolescent/Adult Psychology

FAITH COOK, PSYD
Adult Psychology

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Adolescent/Adult/Couples Counseling

Informed Consent for Telemedicine Service

PATIENT NAME/DATE OF BIRTH: ____

LOCATION OF PATIENT: ____

PATIENT EMERGENCY CONTACT: ____

EMERGENCY CONTACT NUMBER: ____

THERAPIST NAME: ____________________________

Please initial each bullet

- I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to (clinician's name) ________________________ providing health care services to me via telemedicine. I understand that I can only receive telemedicine services from my provider if I am within the state of North Carolina and will notify my provider should my location change so that appropriate referrals to clinicians in that area can be made.

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that my provider will offer me a secure platform to provide telemedicine and should only attempt to use the platform provided. I also understand that it is my responsibility to ensure that I am in a private, secure, and quiet space. As always, your insurance carriers will have access to your medical records for quality review/audit.

- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

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CHIMENE MATHIS, B.S.
Chief Executive Officer

BRITTANY BUTTERY, B.S.
Practice Administrator

- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Sylva Clinical Psychology (my clinician at this office) at 828-586-5555. As long as this consent is in force (has not been revoked) (clinician's name) ____________________ may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

- I understand that sometimes the transmission of electronic services can be unexpectedly interrupted beyond either part's control (e.g., due to loss of internet connection, poor connection, computer failure). Should this occur, I agree to hold my provider harmless during delays of communication or loss of information due to a technology failure.

- I understand that there are certain limitations to telemedicine and that the benefits may not be the same as face-to-face meetings. I understand that there is no guarantee for how I will be impacted by our work together. Should my therapist believe that I would be better served by another form of psychotherapy (e.g., face-to-face services), I will be referred to someone who can provide that service. I understand that should there be some type of emergency, I can call 9-1-1 and/or go to the nearest emergency room for immediate and acute care. I will work with my therapist to create a safety plan as well.

____ ________________

Signature of Patient (or person authorized to sign for patient) *Date*

____

If authorized signer, relationship to patient

I have been offered a copy of this consent (patient's initials): __________