Baldwin Counseling

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CONSENT TO PARTICIPATE IN A TELEHEALTH CONSULTATION

PROVIDER'S NAME AND CREDENTIALS: Suzanne M. Baldwin, Ph.D., LCSW, RN

Patient Name: _____ Date of Birth _____

1. I understand that my health care provider wishes for me to engage in telehealth consultation. I hereby consent to forward my patient-identifiable information to a third party for HIPPA video conferencing. I understand that it is the role of the health care provider to determine whether or not the condition being diagnosed and/or treated is appropriate for telehealth encounter. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are inadequate for the situation.
2. The client *must* be in the State of Virginia during the session.
3. My health care provider has explained to me how the video conferencing technology will be used and the telehealth services can include appointment scheduling, taking payment, patient education, psychotherapy, despite not being in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that all audio, video, file sharing, and chat features require password protection and use the latest encryption protocols to assume that data integrity and privacy are maintained. I will hold the health care provider harmless for information lost due to technical failures.
5. I have had the alternatives to telehealth consultation explained to me, and in choosing to participate in a telehealth consultation, I also understand that some parts of the consultation may require an in-person office visit.
6. In an emergent consultation, I understand that the responsibility of the healthcare provider is to notify my local provider or emergency services and that my healthcare provider's responsibility will conclude upon the termination of the video conference connection. It is my responsibility to notify my provider of my physical location during each meeting.
7. I understand that billing will occur just the same as in-person visits and I am responsible for all charges not covered by insurer as per the previously signed financial agreement.
8. I have had a direct conversation with my healthcare 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.
9. This authorization expires one year from the date signed.

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

_____ _____ _____

Patient/Parent/Guardian Date Time