**Collins Family & Addiction Medicine**

**4777 Andrew Jackson Parkway, Suite 102, Hermitage TN 37076**

**Phone#615-915-2226 Fax#629-202-7956**

**Informed Consent for Telehealth Services**

 Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **I understand that I have the following rights with respect to telehealth/telemedicine**:

1.**Definition of telehealth/telemedicine**. Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

 2. **Right to care**. I understand that the same standard of care that applies to an in-person visit will apply to a video visit. I understand that I have the right not to participate or decide to stop participating in a video visit and that my refusal will not affect my right to future care or treatment.

 3. **Patient information & confidentiality**. I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that video, audio, or photographs may be stored with my consent, and that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician, and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

 4. **Communication risk & consent**. I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined, that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. I understand that my consent will be obtained to receive SMS (text) messages to my mobile device.

 5**. Insurance & Billing**. I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my video visit. I understand that health plan payment policies for video visits may differ from in-person visits.

6. **Group therapy**. I will not record or photograph any part of the group or the group members, or allow anyone into my room while the group is in session. I understand that I may learn the full names of group members due to their name being listed on the video. I agree not to seek out any information about group members (e.g., using a search engine or social media), nor contact them outside of group if this is against the specific group agreements. By joining the group, you are agreeing that you are in an environment where others cannot overhear the group's dialogue or see your screen. If the group facilitator notices that nonmembers are visible or audible during the session, they will ask you to secure your environment and/or leave the group until privacy can be attained. The group facilitator reserves the right to remove you from the group, if you do not do so yourself. If you are removed, the group facilitator will check in with you after the session ends.

By my signature below, I hereby state that I have read, understand, and agree to the terms of this document.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_\_\_**

Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_