ANNA T. MICCI, LICSW
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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals and remote patient monitoring are all considered telehealth services.

- I understand that telehealth involves the communication of my mental health information in an electronic or technology assisted format.
- I understand I may opt out of the telehealth visit at any time.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier and it is my responsibility to check with my insurance plan to determined coverage.
- I understand that all electronic medical communication carries some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but not limited to:
  - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
  - Electronic systems that are accessed by employers, friends or others are not secure and should be avoided. It is important for me to use a secure network.
  - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I agree that information exchanged during my telehealth visit will be maintained by my health care provider.
- I understand that all medical information, including medical records are governed by federal and state laws that apply to telehealth.
- I understand that Face Time, Skype or a similar service may not provide a secure HIPPAA-complaint platform but I willingly and knowingly wish to proceed.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breeches of confidentiality caused by an independent third party or me.

- I agree that I have verified to my healthcare provider my identity and current location in connection with telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- I understand that **electronic communication cannot be used for emergencies or time sensitive matters.**
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that my healthcare provider may choose to forward my information to an **authorized third party.** Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 Services in my community.**

I certify that I have read and understand this agreement prior to my signature with opportunity to have questions answered to my satisfaction, for communication between Anna T. Micci, LICSW and ___________________________.

Patient's name

____ ____________________________

Patient or Legal Representative Signature/Date/Time Relationship to Patient

____

Print Patient or Legal Representative Name

I certify that I have explained the nature of this this agreement to the patient/patient's legal representative. I have answered all questions fully and I believe that the Patient's *legal representative (circle one*) fully understands what I have explained.

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Healthcare Provider Signature Date/Time