Informed Consent for Telehealth/Telemedicine Services

I____ hereby consent to engaging in telehealth/telemedicine services with Coastal Medical and Psychiatric Service, Inc. as part of my mental health resources, psychotherapy, and medication management. I understand that telehealth/telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand the telehealth/telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Virginia.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such I understand that the information disclosed by me during my therapy/treatment is generally confidential. However, there are both mandatory and permissive expectations of confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards a victim; or threatening to harm myself.
3. I understand that there are risks and consequences for the telehealth/telemedicine, including, but not limited to the possibility, despite reasonable efforts on the part of the practice, the transmissions of my medical information could be disrupted by technical failures.
   In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face to face services. I also understand that if my provider believes I would be better served with a face to face visit or the conditions where telehealth/telemedicine should be terminated, the patient will return to in person care.
4. I understand that I will be responsible for any copayments, coinsurance, or deductibles that apply to my telehealth/telemedicine visit.
5. I understand that all existing laws regarding your access to medical information and copies of your medical records apply to this telehealth/telemedicine consultation.
6. I understand that the telehealth/telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

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Printed Name of Patient

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Signature of Responsible Party Date