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TELEHEALTH INFORMED CONSENT FORM

Please complete this form. It intends to educate you and obtain your permission to participate in a Telehealth consultation.

PATIENT NAME		DOB		DATE OF TELESESSION	____ Any dates beginning today ____ Only on _____

INTRODUCTION

Telehealth uses interactive video conferencing that enables a healthcare provider at a distant location to provide treatment to me and/or consult and advise my local healthcare provider in making decisions about the care provided to me. I understand that such a session will not be the same as a direct patient/mental health care provider visit because I will not be in the same room as my health care provider. Telehealth will allow me to receive mental health care without the need to travel long distances to receive services from a distant specialist.

POSSIBLE RISKS

As with any psychological procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

In certain cases, information may not be sufficient to allow for medical decision making by the physician and/or mental health consultant(s).

Delays in treatment could occur due to interruptions and/or failures of the video and/or audio equipment.

Notwithstanding best efforts to protect patient information, security protocols could fail, causing a breach of privacy of personal medical information.

However, every effort has been made to secure all medical records and confidential information. The company we use for our video software is medical grade and encrypted to the highest level.

EXTENSION OF OUTPATIENT THERAPY AGREEMENT

This Telehealth Informed Consent form is an addition to Dr. Jann's Outpatient Therapy Agreement, a copy of which is available at drjann.com.

RELEASE OF INFORMATION

Notes about our telesession are maintained in the same manner that traditional psychotherapy notes are kept. All existing laws regarding access to your medical information and copies of your medical records apply to a Telehealth consultation. Additionally, dissemination of any patient information from this Telehealth interaction to other entities shall not occur without your written consent.

FINANCIAL RESPONSIBILITY

In consideration for the Telehealth services rendered to me, I agree to pay the charges not covered by any third party payer, including any deductible, co-payment, or coinsurance, as well as any charges not covered because of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third party payer.

DISPUTES

I agree that any dispute arriving from the telemedicine consult will be resolved in the State of Georgia and that Georgia law shall apply to all disputes.

PROXY

If I have signed this consent agreement on behalf of a person who may be temporarily or permanently incompetent, unable to sign, or a minor, I represent that I have the authority to sign this consent agreement on behalf of this person. This use of the first person in this consent agreement shall include me and the person whom I represent.

I have read and understand the information provided above regarding Telehealth, have had a chance to discuss it with my Dr. Jann or such assistants as may be designed, and have had the chance to have all my questions answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my treatment.

Signature of Patient
or Next of Kin, Legal Agent/Guardian

Relationship to Patient

If patient is unable to sign and consent of Next of Kin or Legal Agent/Guardian has been secured, indicate the reason below

___ Minor
___ Disoriented
___ Medically Unstable
___ Incompetent

_____

Date