Lakeview TMS Center

LAKEVIEW TMS CENTER

TELE HEALTH COMMUNICATION CONSENT

1. Introduction

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.

Telehealth involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this form is to obtain your consent to participate in a Telehealth consultation for various psychiatric/ medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.

2. Confidentiality

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth consultation.

3. Nature of Telehealth Consent

During the Telehealth consultation: Details of your psychiatric/ medical history, examinations and tests will be discussed using interactive video and/or audio, A virtual examination may take place, Other medical professionals such as nurse practitioners, assistants and/or Scribes may be present during the visit to assist the provider and Photographs may be taken of you during the service. In an emergency, it is the responsibility of the Telehealth provider to direct the patient to emergency medical/psychiatric services, such as an emergency room. The Telehealth provider may also discuss and advise with the patients local provider (if applicable). The Telehealth providers responsibility will end upon the termination of the Telehealth connection. I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records and copies of medical records.

4. Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation.

I understand that all electronic medical communications carry 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 are not limited to It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge an 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 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 breaches of confidentiality caused by an independent third party or by me.

5. Billing and Payment

Lakeview TMS Center is a fee for service psychiatric office and provider do not participate as in network with insurance plans. Your appointment payment is due in full at prior to your appointment. It is your responsibility to contact your insurance company to verify your out of network rates of reimbursement. We classify your appointment as self-pay and you are able with commercial insurance to file for out of network benefits EXCEPT Medicare. You MAY NOT file with medicare and must inform us if you have medicare coverage. Telehealth services may not be covered by all insurance plans. Non-covered Telehealth visits will be the patients full responsibility.

6. Your Rights & Responsibilities

You may withhold or withdraw consent to the Telehealth consultation at any time in WRITING without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

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 she is my healthcare provider. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit I understand that electronic communication cannot be used for emergencies or time sensitive matters. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendation including further diagnostic/psychological testing, lab testing, or an in-office visit. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

☐ I Consent to Telehealth *

By checking the above box and signing below, you are certifying you have read, understand and agree to all conditions indicated on the telepsychiatry consent and agree for Lakeview TMS Center providers to utilize this modality to provide your psychiatric care and management of treatment.

Email: _____ Phone Number: _____

Signature of Patient or Legal Guardian: _____

First and Last Name of person signing form: _____

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