MERIDIAN
PSYCHOTHERAPY SERVICES LLC

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Informed Consent for Telemedicine Services

I understand my healthcare provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. I hereby consent to forward my patient-identifiable information to a thrid-party for HIPAA compliant video conferencing. I understand that my healthcare provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation. The telemedicine provider understands that they are responsible for using this technology in a secure and private location so that others cannot hear the conversation.

Telemedicine services can include prescription refills, appointment scheduling, taking payment, patient education, psychotherapy, despite not being in the same room as my health are provider.

I understand that billing will occur just the same as in-person visits. I have been informed by the staff that telehealth may not be a covered benefit of my insurance plan and still wish to conduct the appointment via telehealth. I understand that I will be responsible for payment in full for any telehealth charges not covered by insurance.

Patients engaging in telemedicine services agree:

- to engage their sessions in a private location where they cannot be heard by others.
- to use a private phone.
- that they will **not** record any sessions.
- to use password protection on any technology utilized during the telemedicine encounter.
- to always log out or hang up once sessions are complete.
- to provide credit card information to keep on file for co-pays.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties for which I agree to hold my healthcare provider harmless.

I have had a direct conversation with my healthcare provider or his/her representative, during which I had the opportunity to ask questions and wish to engage in telemedicine services.

I hereby consent to forward my patient-identifiable information to a thrid-party for HIPAA compliant video conferencing.

_____ _____
SIGNATURE OF PATIENT SIGNATURE OF PARENT/LEGAL GUARDIAN

_____ _____
PATIENT NAME DATE

email address:_____

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