SHRINK SAVANNAH

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# PATIENT TELEHEALTH CONSENT AGREEMENT

I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

I agree to use the video-conferencing platform selected for our virtual sessions via a webcam or smartphone, and the provider or office Administrative team will explain how to use it.

I understand t is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

I understand it is important to use a secure internet connection rather than public/free Wi-Fi.

I understand I need to be on time and if I need to cancel or change my telehealth appointment, I must notify Shrink Savannah at least 24 hours in advance by phone or through the website form at ShrinkSavannah.com.

I will provide an alternate phone number where I can be reached to re-start the session in the event of technical problems.

I understand the need for a safety plan that includes at least one emergency contact and the closest emergency room to my location, in the event of a crisis situation.

Emergency Contact: _____ Relationship: _____ Phone: _____

Closest Emergency Room: _____ Location: _____

I understand it is my responsibility to confirm with my insurance company whether the telehealth sessions will be reimbursed; if they are not reimbursed, I am responsible for full payment on the day of my appointment.

I _____ FULLY UNDERSTAND AND I HEARBY
☐ ACCEPT
☐ DECLINE
THE TERMS OF THIS CONSENT

_____ _____
PATIENT DIGITAL SIGNATURE DATE

Please select your provider(s). If unknown, leave blank.

☐ Chad Brock, MD
☐ Kristy Triplett, PA-C
☐ Lydia Stearns, PA-C
☐ Andrea Yates, PA-C
☐ Heather Martin, APRN
☐ Margaret Alexander, LCSW
☐ Rebecca Fain, LPC, CCMHC
☐ Kim McGraw, LCSW
☐ Chene Walz, LPC, CCMHC