LAGUNA FAMILY HEALTH CENTER-TELEHEALTH PATIENT CONSENT FORM

In order to receive telehealth services from Laguna Family Health Center, you must be a California State Resident and/or be currently present in California during the time of your telemedicine appointment.

Telepsychiatry / Teletherapy is the delivery of psychiatric & psychological/counseling services using interactive audio and visual electronic systems between a provider and a patient/client that are not in the same physical location. These services may include consultation, treatment, assessment, diagnosis, electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, emails, telephone conversations and distribution of patient education materials.

I understand the following rights, risks and responsibilities with respect to telehealth services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, I understand that the information disclosed by me during the course of my treatment is confidential. However, there are both mandatory and permissive exceptions to confidentiality, as outlined in the general intake packet.

3. I understand that there are risks and consequences from telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures and the transmission of my medical information could be interrupted by unauthorized persons.. Laguna Family Health Center utilizes software that meets the standards to protect the privacy and security of the sessions and is HIPAA compliant. However, the service cannot guarantee total protection against hacking or tapping into the session, although the risk is minimal.

4. I understand that there could be some technical problems (video quality, internet connection) that may affect the telehealth session and could affect the decision making capability of the provider.

5. I understand that telehealth based services and care may not be as complete as face-to- face services. If my provider believes I would be better served by another form of services (e.g. face-to- face services), I will be referred to a provider who can provide such services in my area and/or be requested to come into the office. The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.

6. I understand that there are potential risks and benefits associated with any form of psychiatry or psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse. I may benefit from telehealth services, but that results cannot be guaranteed or assured.

7. I understand that I have a right to access my medical information and copies of my records in accordance with California Law.

8. I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

9. I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

10. I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I hereby consent to engaging in telehealth services with LAGUNA FAMILY HEALTH CENTER as part of my psychiatric/psychotherapy evaluation and treatment. I have read and understand the information provided above regarding telepsychiatry / teletherapy and understand my rights, responsibilities, and risks.

Patient / Guardian Signature *Date*