CARROLL COUNSELING CENTERS
TELEMEDICINE INFORMED CONSENT FORM

1. I understand that my health care provider wishes me to engage in telemedicine consultation. I understand that "telemedicine" includes consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications.

2. I understand that telemedicine involves the communication of my medical/mental health information, both orally and/or visually

3. I understand that there are potential risks to this technology despite best efforts to ensure high encryption and secure technology on the part of my provider, including interruptions, unauthorized access, and technical difficulties.

4. I understand that the laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information I disclosed during my therapy or consultation is generally confidentiality. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general consent form I received at registration.

5. I understand if others are present during consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: a) omit specific details of my medical history/physical examination that are personally sensitive to me; b) ask non-medical personnel to leave the telemedicine treatment room; and or c) terminate the consultation at any time.

6. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

7. I accept that telemedicine does not provide emergency services. If I am experiencing an emergency, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer with audio and visual capability, telecommunications equipment, and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telemedicine session. The provider is responsible to do the same from his/her end.

9. I understand that I will have a direct conversation with my healthcare provider, in which I will have the opportunity to ask questions regarding this procedure. My questions will be answered to the best of the providers knowledge and the risks, benefits, and any practical alternatives will be discussed with me in a language that I understand.

10. I am not allowed to make an audio and/or video recording of the telesession without the signed consent of the provider. Violation of this agreements may be subject to legal action.

I have read, understand, and agree to the information provided above regarding telemedicine.

_____	_____	____/____/_____
Patient/ Guardian Signature	Patient / Guardian Printed Name (First & Last)	Date