Best Life Mental Health Services, LLC

Form Title: Telemedicine/teletherapy consent

INTRODUCTION
Telemedicine/teletherapy involves the use of synchronous electronic communications to enable clinicians and patients/clients to work together remotely.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS
● Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site)
● More efficient medical evaluation and management.
● Obtaining expertise of a distant specialist.

POSSIBLE RISKS
As with any medical procedure, there are potential risks associated with the use of telemedicine/teletherapy. 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 physician and consultant(s);
● Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
● In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
● In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

By signing this form, I attest to and understand the following:
1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/teletherapy, and that no information obtained in the use of telemedicine/teletherapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine/teletherapy in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My clinician has explained the alternatives to my satisfaction.
4. I understand that I may expect the anticipated benefits from the use of telemedicine/teletherapy in my care, but that no results can be guaranteed or assured.

CONSENT TO THE USE OF TELEMEDICINE
I have read and understand the information provided above regarding telemedicine/teletherapy, have discussed it with my clinician or his/her assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine/teletherapy in my medical care, and hereby authorize my clinician to use telemedicine/teletherapy in the course of my diagnosis and treatment.

*** Signature (required)**