Holistic Mental Health, PLLC Telemedicine Consent Form

I, _____ hereby give consent to Dr. Benjamin Ose with Holistic Mental Health, PLLC to engage in a HIPAA-compliant video teleconference (VTC) session via a third-party online service in lieu of a face-to-face session when an in-person session is not feasible. I understand that a VTC session is not to be used solely for the sake of convenience. I understand I may revoke this consent in writing at any time. INITIALS_____

I understand that telemedicine is different from traditional medicine in that sessions will occur remotely via a HIPAA-compliant VTC service. I am familiar with the technology required for conducting telemedicine sessions and I will conduct all sessions from a private, well-lit location. INITIALS_____

I understand that some benefits of video telemedicine include increased access to medical care and possible greater insurance reimbursement than a telephone session. I understand that some of the risks include (a) failure of VTC technology such that an appropriate medical evaluation becomes impossible and (b) breach of confidentiality due to encryption failure or legal or illegal investigation. INITIALS_____

I understand that Holistic Mental Health, PLLC is not responsible for any breach of data from a third-party vendor utilized to provide services for VTC sessions. INITIALS _____

I understand that there may be technical limitations associated with receiving treatment via telemedicine; equipment may fail and my doctor may determine at any time that the quality of the connection is not sufficient to continue. I agree to attempt to continue a session by telephone in case of VTC equipment failure. INITIALS_____

I understand that the laws that apply to the practice of medicine and to the privacy of health care information also apply to telemedicine. INITIALS_____

I understand that Holistic Mental Health, PLLC is not responsible for the maintenance, purchasing of internet service, personal computers, web cameras, microphones or other equipment or software needed to teleconference with my doctor. INITIALS _____

I understand that no recordings of my sessions will be done by Holistic Mental Health, PLLC and I also agree not to record any VTC sessions with my doctor. INITIALS _____

I understand that if I have privacy concerns about doing a VTC session, I can opt to do a phone session for a limited number of sessions and discuss the frame of treatment with my doctor. INITIALS _____

I HAVE READ AND AGREE TO THE TERMS OF TREATMENT ABOVE.

Patient Name: _____ Patient Signature: _____ Date: _____

Parental Signature (If patient is a minor): _____ Date: _____