

Steven E. Locke, MD

10 Deer Run, Wayland, MA 01778

(508) 343-0001 Phone | (508) 213-3776 Fax

steven.locke@drstevenlocke.com | www.drstevenlocke.com

PATIENT TELEHEALTH CONSENT FORM

I. INTRODUCTION

I understand that my continued medical care could be facilitated by using telehealth for my therapy. My provider has informed me of the benefits and risks of using telehealth as a method of health care delivery. As a result of this discussion, I have decided to use telehealth for my care. I have signed this form electronically at my first telehealth appointment after having been given an opportunity for my provider to answer any questions. I understand that a signed copy of this form will be placed in my medical record.

II. BENEFITS

- I understand that my provider believes that telehealth will benefit my care.
- I understand that under certain conditions, such as during an epidemic when public health authorities have recommended self-quarantine or social distancing, it may be safer to receive care at home rather than travel to a doctor's office or other clinical setting.
- I understand that telehealth doesn't replace the potential need for in-person appointments between me and my provider. This determination will be made by my provider.
- My provider has given me instructions on the proper use of telehealth and has answered all my questions to my satisfaction.

III. FEDERAL and STATE LAW

Federal law requires that health care providers protect the privacy and security of my personal health information.

- I understand that my provider has undertaken reasonable efforts to provide a system designed to protect the security and privacy of my personal health information using HIPAA-compliant protocols, including the selection of technology partners who are also governed by federal and state regulatory requirements regarding the protection and privacy of patient health information, at the provider's location.
- I understand that my provider must inform me of the location of provider rendering services and obtain the location of the patient receiving services.
- I understand that federal and state law is changing rapidly in response to the COVID-19 epidemic and that this provider will use technology that is allowable by state and federal law.

IV. RISKS

- I understand that my telehealth sessions help my provider care for me but may be different from in-person, face-to-face treatment. If the standard of care cannot be maintained using this method of healthcare delivery, my provider will notify me that this is the case and advise me to seek in-person care.
- I understand that there are risks and consequences from telehealth, including, but not limited to, disruptions or distortions of video and audio transmission due to technical difficulties. Deficiencies or

failures of the equipment could result in delay in medical evaluation or treatment and could affect the treatment session.

- There is potential for unauthorized interruptions by third parties.
- I understand that my insurance carrier may refuse to pay or reimburse for telemedicine, in which case I will be responsible for payment.

V. CONSENT

- I understand that I may withdraw my consent to continue treatment by telehealth at any time. However, any treatment received from my provider prior to receipt of my withdrawal of consent will not be affected.
- My withdrawal of consent and termination of telemedicine-based treatment will not affect my current or future treatment by my provider.
- I understand that I am responsible for providing equipment and internet or telephone access for telehealth.
- I understand that I am responsible for arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth appointments.
- No third parties shall be present or have access to a telemedicine session during its occurrence without my and my provider's written permission.
- I understand that it will be my responsibility to determine whether my insurance carrier will provide coverage for any treatment I receive, and I will be responsible for full payment in the event that the insurer denies coverage.
- I have had the opportunity to ask questions about the use of telemedicine including the risks and benefits and my provider has answered all of my questions to my satisfaction.

I have read and I understand the information provided above regarding my treatment by telehealth and have been given the opportunity to ask questions of my provider.

SIGNATURE OF PATIENT OR GUARDIAN	
NAME	

If personal representative, please provide patient's name and relationship to patient (e.g., parent, guardian, etc.)

DATE	
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SIGNATURE OF PROVIDER	
DATE	