NWA Premier Therapy
Your path to a better life

Telehealth Consent

CLIENT NAME:____

DATE OF BIRTH:______________________

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- File transfer
- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

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

Expected Benefits:

- Improved access to care by enabling a client to remain in his/her provider's office (or at a remote site) while the providers consults from practitioners at distant/ other sites.
- Efficient client evaluation and management.

Possible Risks:

There are potential risks associated with the use of telehealth. 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 decision making by the providers and consultant(s);
- Delays in 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 health information

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth 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 telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telehealth

I, _________________________________ have read and understand the information provided above regarding telehealth, have discussed it with my provider or such 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 telehealth in my care.

Signature of Client (or person authorized to sign for client):

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Date

____

If authorized signer, relationship to client:

____

Witness:

I have been offered a copy of this consent form (client's initials)

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