Women's Health Partners, LLC

Diplomates American Board of Obstetrics & Gynecology

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Informed Consent for Telehealth

I understand that Telehealth is a mode of delivering health care services, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. By signing this form, I understand and agree to the following:

1. I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during an in-person visit.
2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my clinician, that my session and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons. Women's Health Partners utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver Telehealth via Doxy.me.
3. I understand that miscommunication between myself and my clinician may occur via Telehealth.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment.
5. I understand that at the beginning of each Telehealth session my clinician is required to verify my identity.
6. I understand that in some instances Telehealth may not be as effective or provide the same results as an in-person visit.
7. I understand that if my clinician believes I would be better served by an in-person visit, my clinician will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other clinicians who can provide such services.
8. I understand that while Telehealth has been found to be effective in treating a wide range of clinical issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
9. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my clinician may record the sessions without the other party's written permission.
10. I further understand that my clinician may not be able to assist me in an emergency. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

Payment for Telehealth Services:
I understand that I may or may not be covered under my current health insurance plan for telehealth services. Insurance coverages have been changing rapidly due to multiple factors. Your insurance or you (self-pay) will be billed at our usual rates for office visits and you are responsible for payment, copays, or deductibles. I agree to pay any costs I incur for the visit.

Patient Consent to the Use of Telehealth:
I have read and understand the information provided above regarding Telehealth. I have read this document carefully and understand the risks and benefits related to the use of Telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of Telehealth services for treatment under the terms described herein. By my signature, I hereby state that I have read, understood, and agree to the terms of this document.

_____	_____	_____
Patient or Legal Guardian Signature	Date	Account #
_____		
Patient Name (Print)		
_____	_____	
Witness	Date	