SOUTH LINCOLN PSYCHIATRY, LLC

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TELEHEALTH PATIENT CONSENT FORM

I,_____, hereby give my consent to (circle one)
Kelli D. Bremer M.D., P.C. **or** Buda Psychiatry, P.C., to provide telehealth services to me

OR

I,_____, (Parent/Guardian) to the above name patient, hereby give my consent for treatment.

____I allow Kelli D. Bremer, M.D., P.C. or Buda Psychiatry, P.C. to file for insurance benefits to pay for the telehealth care that I receive.

____I understand that:

- Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, P.C. may send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

____I understand that the telehealth services provided to me through South Lincoln Psychiatry, at 2001 Pine Lake Rd, Ste 300, may be conducted at the location previously mentioned or at an alternative site and that my provider will take every possible action to ensure that if there is an alternative site for my telehealth appointment, that the site is private and secure.

____I understand that the same confidentiality protections that apply to my other medical care as outlined in my previous Consent for Treatment contract will also apply for the telehealth services.

____I understand that telehealth services mean that my appointment with my provider will happen by using special audiovisual equipment, may occur outside of the doctor's private office and technology has the potential for undesired breaches that cannot always be anticipated, therefore creating potential risks.

____I understand that SLP will be prudent in using HIPPA compliant and encoded technology to protect my information in every possible way to minimize all risks of any confidentiality breaches.

____I understand that as my previous treatment contract stated, the information from the telehealth services cannot be released to other providers or anyone else without my consent. I will be informed of all people who will be present at all sites during my telehealth service.

____I understand that it is my responsibility to ensure my own privacy on my end by finding a secure private room for my appointment. I may exclude anyone from any site during my telehealth appointment.

____I understand that I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.

____I understand that I may have to travel to see a health care practitioner in-person if I decline the telehealth service and that we may need to discuss the pros and cons of this option if there are any safety issues involved.

____I understand that assessing and evaluating threats or severity of illness can sometimes be more difficult when conducting telehealth than in traditional in-person appointments. If the session is interrupted for any reason, including technological connection fails, and I am having an emergency, I should call 911 or go to my nearest emergency room and call the office back after I have obtained emergency services.

____I understand that if our session is interrupted, and there is not an emergency, SLP providers will give best faith effort to reconnect by phone or by reconnection with telehealth if at all possible for further direction and that I as a patient will also attempt to follow through with a follow up plan and direction for treatment.

____I understand that in general, we know that there is good evidence that telehealth has been shown to be highly comparable and as effective as in-person appointments in most cases, so our hope would be to avert emergencies and trips to the ER if at all possible.

____I understand this consent is valid for the duration of treatment with South Lincoln Psychiatry and that it is intended to be a supplement to the initial paperwork that I signed at the time I became a patient.

Your signature below indicates your understanding of the contract and agreement.

PRINT NAME_____ **Date:** _____

SIGNATURE of PATIENT_____ **Date:** _____

SIGNATURE of PARENT/GUARDIAN_____**Date:** _____