

**SOUTH LINCOLN PSYCHIATRY, LLC**

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**TELEHEALTH PATIENT CONSENT FORM**

I, \_\_\_\_\_, hereby give my consent to (Select 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 HIPAA 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:** \_\_\_\_\_

