Name: _____ **DOB: _____**

KNOXVILLE FAMILY PSYCHIATRY

INFORMED CONSENT FOR TELEMEDICINE (TELEHEALTH) SESSIONS

1. Telehealth is any meeting with a healthcare provider via a phone call or a video call in place of an in-person session.

2. I understand that my health care provider wishes me to engage in telehealth as an alternative to an in-person session or sessions.

3. My provider has explained to me how the video conferencing technology will function and how it will differ from an in-person session.

4. I understand that a telehealth session has potential benefits, including greater access to care and the convenience of meeting from a location of my choosing.

5. Client Communication and Responsibilities:

a. I understand I will need to have access to and be familiar with the appropriate technology in order to participate in this service. I agree to use my own equipment and not equipment owned by another.

b. I agree not to use my employer's equipment. I understand that any information I enter into an employer's equipment can be considered by the courts to belong to the employer, and my privacy may be compromised.

c. It is my responsibility to maintain privacy on the client end of communication. I agree to use a secure and private environment while "meeting" with my practitioner. I will not allow any other person(s) in the session unless discussed and agreed upon with my counselor.

6. I understand that my provider is using a HIPPA compliant platform (AdvancedMD via Zoom or 3CX Platform). However, I also understand that there are potential risks to this technology, including interruptions, unauthorized access by others, and technical difficulties. I recognize that the transmitted information may be unclear or inadequate. I understand that my provider will exercise care to minimize these risks, and in the case of disruption that the provider will then attempt to call the client via other means.

7. I understand that telehealth sessions are not adequate for emergency situations and my provider will require me to contact a local crisis response team or go to the nearest emergency room in an emergency situation.

8. I acknowledge have read the document and fully understand the benefits and risks. I have had the opportunity to ask questions and received satisfactory information.

9. I voluntarily consent to participate in the telehealth services, including but not limited to care, treatment, ad services deemed necessary and advisable under the terms described herein.

CONSENT TO USE ADVANCEDMD TELEMEDICINE (VIA ZOOM) or the 3CX Platform, which is the technology services we will use to conduct telehealth video conferencing appointments. By signing this document, I acknowledge: This is not an emergency service, and in the event of an emergency, I will use a phone to call 911.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. By signing this form, I certify: I have read or had this form read to me or had this form explained to me. I fully understand its contents, including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Signature of client ages 16 or older /
Signature of legal guardian for minor under age 16

Date