Balance Behavioral Health PLLC
6504 Woodlake Village Circle
Midlothian, VA 23112
ph: 804-823-5475
fax: 804-818-3644

Informed Consent for Telemedicine Services

PATIENT NAME: _____ **DATE OF BIRTH:** _____

EMAIL ADDRESS: _____

PHONE NUMBER WHERE YOU CAN BE REACHED AT TIME OF APPOINTMENT: _____

CLINICIAN NAME: _____ **DATE CONSENT DISCUSSED:** _____

Introduction: Telemedicine involves the use of electronic communications to enable behavioral health care provider in one location to communicate with a patient in a different location at times when in-office meetings are not possible. The information discussed may be used for diagnosis, therapy, follow-up and/or education. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient 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 medical care by enabling a patient to remain in his/her preferred location. • More efficient medical evaluation and management. • Obtaining expertise of a distant specialist.

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. 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 medical decision making by the health care provider • 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 medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine 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 telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My behavioral healthcare provider has explained the alternatives to my satisfaction.

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5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform my behavioral healthcare provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my behavioral healthcare provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my behavioral health care.

I hereby authorize _____ (name of behavioral healthcare provider/therapist) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____ Date: _____

If authorized signer, relationship to patient:

Witness: _____ Date: _____