ARBOR PSYCHIATRIC AND WELLNESS CENTER

TELEHEALTH CONSENT

Patient Name (Last, First, MI)		DOB:
Patient Address	Phone Number	
Email		

1. I understand that my health care provider at Arbor Psychiatric & Wellness Center (Lindsey Teten, PMHNP, APRN-NP; Pamela Bennett, LIMHP, LCSW) wishes me to engage in a telehealth consultation via video conferencing technology.
2. My provider has explained to me how the telehealth technology will be used and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. All existing confidentiality protections shall apply to my telehealth consultation.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the telehealth connections are not adequate for the situation.
5. I understand that I will be informed of all people who will be present at all sites during my telehealth service. I retain the right to exclude anyone from the originating or distant site.
6. I have had the alternatives to a telehealth consultation explained to me, and I am choosing to participate in telehealth. I have the option to decline telehealth. At this time, the alternatives have been explained to me as waiting to be seen until in-person visits can resume, or seeing another provider at a different office.
7. I retain the right to refuse telehealth consultations at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
8. I have had a direct conversation with my provider, during which I have had the opportunity to ask questions in regards to this process. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
9. Arbor Psychiatric & Wellness Center will utilize current billing practices for telehealth. I understand that my policy may not cover telehealth services and that I am financially responsible for all charges incurred.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the process and procedure.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship: _____