Telehealth Informed Consent

I _____ hereby consent to engaging in telehealth (e.g. Internet or telephone consultation) with Jennifer Stagg, ND, Mark Stagg DC, Aylah Clark ND and Karen Bender ND. I understand that "telehealth" includes the delivery of health information, transfer of medical data, and education using interactive audio, video, or data communications with a health care provider who may be located in other areas, including out – of – state. Unless you have received medical care at my practice in Avon, CT and established a client-doctor relationship, phone and any internet communication will be considered consultation, coaching and educational in nature and not physician treatment.

Your rights with respect to telehealth:

1. I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that information disclosed by me during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse, expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand a variety of alternative methods or health care may be available to me, and I may choose one or more of these at any time. My doctor has explained the alternative care methods to my satisfaction.

Potential Risks:

1. I understand that there are risks and consequences from telehealth, including but not limited to, the possibility despite reasonable efforts on the part of my doctor, that the transmission of ***my medical information*** could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur.
2. I understand that telehealth based services and care may not yield the same ***results*** nor be as complete as face-to-face service. The remote nature of telehealth practice can also increase patient risk because a distant doctor cannot perform comprehensive physical examinations. Without completing a hands-on examination, the distant doctor's ability to offer a complete and accurate evaluation of the patient's condition may be limited.
3. I understand that ***information transmitted*** may not be sufficient to allow for appropriate medical decision-making by my primary physician or doctor.

Please initial after reading this page: _____ and sign next page

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4. My distant doctor may not be able to provide medical treatment to me using telehealth equipment nor provide or arrange any emergency care I may require. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. I also understand that if my doctor believes I would be better served by another form of service (e.g. face-to-face service) I will be referred to a practitioner in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of telehealth, and that despite efforts of my doctor, my condition may not improve, and in some cases even get worse.

5. I understand I have a right to access my medical information and copies of my medical records at a fee.

Cost:

The fee for this service is $75.00 per 15 minutes unless you have insurance that covers. No refunds available. Client is responsible to pay in advance of the appointment by calling 860-674-0111. If you have an insurance policy that covers, we will bill your insurance.

I have read the above fees and policies and understand the cost of my care. I understand that I am responsible for payment of all deductibles and copays related to my care. I understand my insurance company is billed as a courtesy, and I further understand that I am responsible for any amount that my insurance company does not pay. ***Initials***_____

Patient Consent to the Use of Telehealth

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

Print name of client_____
Signature of client _____
Date _____