Mind Rejuvenation, LLC
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Telehealth Services Informed Consent

Patient Name:_____ DOB:_____Date:_____

Definition of Telehealth:

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.
2. I understand that during the use of telehealth conferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access, and technical difficulties. I understand my heath care provider or I can discontinue the video conference visit if it is believed video conferencing technologies are not adequate for the situation.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care treatment.
5. I understand that telehealth 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 no results for anticipated benefits can be guaranteed or assured by my provider.
7. I agree certain situations - such as emergencies and crisis -- are inappropriate for audio-/ video-/computer- based services. If I am in crisis or in an emergency, I should immediately call 911 or see help from a hospital or crisis-oriented healthcare facility in my immediate area.
8. I understand my healthcare information may be shared with out individuals for purposes of scheduling and billing. Individuals other than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session.
   Furthermore, I have the right to request the following:
   a. Ask non-medical personnel to leave the telehealth examination room: and/or
   b. Terminate the appointment at any time.

Consent to The Use of Telehealth

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 procedure(s)
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient / Parent / Legal Guardian PRINTED Name | Patient / Parent / Legal Guardian Signature

_____ _____

Witness PRINTED Name | Witness Signature