CONSENT TO PARTICIPATE IN A TELEHEALTH ENCOUNTER FOR GROUP THERAPY

PATIENT LABEL HERE

I. DESCRIPTION, PURPOSE AND BENEFITS

I have been informed that video conferencing equipment will be used to provide a physician or licensed designee encounter via electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, remote monitoring, and real-time interactive services. I also have been informed that the encounter will be somewhat different from an in-person patient encounter since I will not be in the same room as my telehealth physician or licensed designee. I understand that I will undergo a physical evaluation consistent with my presenting symptoms and that a medical assistant, nurse, physician's assistant, or another clinician at the local site will present his or her findings to the physician or licensed designee providing the telehealth encounter. I further understand that I will have an opportunity to speak with the physician or licensed designee and ask questions. My physician or licensed designee has informed me that for purposes of diagnosis, treatment, care management, or coordination of care, it may be necessary to involve other healthcare practitioners in my care, and I hereby authorize the Hospital, members of its medical staff, and healthcare and administrative personnel to make continuing uses and disclosures of my Protected Health Information including sensitive health information protected by federal and state law to the extent necessary to my primary care provider, specialists, other health care practitioners, facilities, entities and MaineHealth organizational affiliates who have been or may become involved in my care both within and outside the State of Maine.

I understand that individuals other than my healthcare providers may be present during the telehealth encounter to operate the video conferencing equipment and that my protected healthcare information also may be shared for scheduling and billing purposes as such information is shared for in-person visits. I further understand that I will be informed of the presence of any non-medical personnel in the encounter area and will have the right to request the following:

i. omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain in the encounter area;
ii. ask non-medical personnel to leave the encounter area; and/or
iii. terminate the telehealth encounter at any time.

I further understand that either my health care provider(s) or I can discontinue the telehealth encounter at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case I will be referred to another healthcare provider for an in-person evaluation.

II. LIMITATIONS AND RISKS ASSOCIATED WITH THE TELEHEALTH CONSULT

I understand that certain limitations exist with a telehealth encounter including a provider's ability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio. I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth encounter. For these reasons, my particular medical needs may require an in-person encounter with a clinician. The physician or licensed designee performing the telehealth encounter or licensed designee will inform me whether a telehealth encounter is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality. I also have been informed that certain medications such as narcotics may not be prescribed during a telehealth encounter.

The physician or licensed designee performing the telehealth encounter or licensed designee also has explained to me that the usual and most frequent risks associated with this type of encounter include interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the encounter; and unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information.

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III. ALTERNATIVE COURSES OF TREATMENT

The physician or licensed designee performing this telehealth encounter or designee has explained to me the reasonable alternative treatment or procedures and, as appropriate their usual and most frequent risks. I understand that the alternative to a telehealth encounter is a visit to another healthcare provider for an in-person evaluation, diagnosis and treatment which may not occur as quickly as a telehealth encounter can be performed.

IV. CONFIDENTIALITY AGREEMENT

When I participate in a telehealth encounter for group therapy, I understand that I will learn information of a confidential nature concerning other participants. I further understand the importance of maintaining the confidentiality of such information and agree to keep all information and experiences shared by other participants in the strictest confidence. In particular, I agree that I will ***not*** disclose to any third parties: (i) the name or identity of any participant; (ii) any communications made by or about the participants; and (iii) any other information that I may learn about the participants as a result of my involvement in this telehealth group therapy.

V. BILLING FOR THE TELEHEALTH CONSULT

I understand that billing for this telehealth encounter will consist of both a consulting fee from the physician or licensed designee performing the telehealth encounter and a facility fee from the site from which I am presented for the encounter. I further understand that available third-party insurance will be billed for such services and that billing statements will be mailed to me following the telehealth encounter with any remaining balances. I further understand that a co-payment is due at the time of the encounter if I am insured with a commercial payor.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to this telehealth encounter, and that I have had ample time to ask questions and consider my decision. I hereby consent to participate in the telehealth services described herein for purposes of examination, encounter, diagnosis and treatment.

Date	Time AM|PM	X Signature ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative	Printed Name

If by telephone consent given by: ❑ Patient ❑ Other ____________ Phone number ____________

Date	Time AM|PM	X Witness Signature (For phone consent or when patient is physically unable to sign)	Printed Name

Interpreter for: ❑ Sign Language ❑ Foreign Language ❑ Other ____________ Print Name or identifying information ____________

Date	Time AM|PM	X Signature of Physician or Designee	Printed Name

Verification of Patient Identity:

❑ State Driver's License ❑ State Identification Card ❑ School/College Identification Card ❑ Passport ❑ Other ❑ Established Patient