LSM Consent to Telehealth Treatment

Dear New Practice Member,

WELCOME TO LAKESIDE MEDICINE!

The following document is comprised of two sections:

INFORMATION REGARDING TELEHEALTH and CONSENT TO TELEHEALTH TREATMENT.

Please read this notice carefully. This describes how telehealth is incorporated with your medical care. Medical information about you is protected the same as it would be with a face-to-face visit. This form also outlines your risks, rights, and responsibilities. Patient is required to have a telehealth consent in their files in case of need as in case of an emergent scenario. You have the right to obtain a paper copy of this notice upon request, even if you have agreed to accept this notice electronically.

Thank you so much!

1. INFORMATION REGARDING TELEHEALTH

Practice: Lakeside Medicine

Provider: Kelly Fuhrman, ARNP

Credentials: Kelly Fuhrman is a board-certified nurse practitioner, licensed to practice medicine in the states of Idaho and Washington.

- □ **I understand**
- □ Others_____

Introduction: Telehealth is the delivery of medical services using interactive audio and visual electronic systems or remote monitoring systems where the provider and the patient are not in the same physical location. The interactive electronic systems used in telehealth incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.*

- □ **I understand**
- □ Others_____

Potential Benefits:

Increased accessibility to medical care, improved and more accurate health status monitoring and patient convenience.

Potential Risks:

As with any medical procedure, there may be potential risks associated with the use of telehealth. These risks include, but may not be limited to: Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by Kelly Fuhrman, ARNP. Kelly Fuhrman may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require. Delays in medical evaluation and treatment may occur to deficiencies or failures of the equipment. Security protocols can fail, causing a breach of privacy of my medical information. A lack of access to all the information that might be available in a face-to-face visit but not in a telehealth session may result in errors in medical judgement.*

- □ **I understand**
- □ Other_____

My Rights:

I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth. I understand that the software platforms used by Kelly Fuhrman, ARNP is HIPPA protected to prevent the unauthorized access to my private medical information. I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment. I understand that Kelly Fuhrman, ARNP has the right to withhold or withdraw her consent for the use of telehealth during the course of my care at any time. I understand that all rules and regulations, which apply to the practice of medicine in the state of Idaho and Washington, also apply to telehealth.*

- □ **I understand**
- □ Other_____

My Responsibilities

I will not record or copy any telehealth sessions without written consent from Kelly Fuhrman, ARNP. I understand that Kelly Fuhrman, ARNP will not record any of our telehealth sessions without my written consent. I will inform Kelly Fuhrman, ARNP if any other person can hear or see any part of our session before the session begins. Kelly Fuhrman, ARNP will inform me if any other person can hear or see any part of our session before the session begins. I understand that, I, not Kelly Fuhrman, ARNP, am responsible for the configuration of any electronic equipment used on my computer, which is used for telehealth. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the state of Idaho or Washington to be eligible for telemedicine services from Kelly Fuhrman, ARNP. I further understand I must be within the borders of these states to receive care via telehealth. It is my responsibility to ensure insurance covers telehealth or I will be charged the full fee for service without discount if I do not determine this ahead of time.*

2. CONSENT FOR TELEHEALTH

I have read and understood the information provided above regarding telehealth. I authorize Kelly Fuhrman, ARNP to use telehealth in the course of my evaluation and treatment.

PATIENT SIGNATURE:

_____

Patient Name *

_____

Date of Birth _____

GUARDIAN'S SIGNATURE:

_____

Name of Guardian (if applicable)

_____

Guardian Date of Birth _____

Today's Date:_____