TELEMEDICINE PATIENT CONSENT FORM

In order to receive telemedicine services from The REDI Clinic of Wauwatosa, SC specialty eating disorder clinic, you must be a Wisconsin State Resident. Telemedicine is the delivery of Behavioral Health services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telemedicine are:

- Reduced wait time to receive Behavioral Health care.
- Avoiding the need to travel to a psychiatrist.
- Reduce the health risk to patients, family, and providers during times of medical crisis.

The potential risks of telemedicine include, but are not limited to:

- A telemedicine session will not be the same and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the telemedicine session and affect the decision-making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face to face visit, but not in a telemedicine session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- The REDI Clinic utilizes software as recommended by the United States Department of Health and Human Services. However, the service cannot guarantee total protection against hacking or tapping into the telemedicine session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telemedicine:

- Traditional face-to-face sessions.
I understand that I have the following rights with respect to telemedicine:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
  - During a period of national emergency, the government has/may wave requirements for levels of security for video conferencing applications (for example we are able to use applications such as skype and FaceTime for telemedicine, though every effort is made to use a HIPPA compliant platform). Be aware that this waving of certain security requirements cannot guarantee total protection against hacking or tapping into the telemedicine session by outsiders.

- (2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my treatment 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.
  - I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

- (3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, 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; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
  - In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychiatrist/Therapist/dietician/Nurse believes I would be better served by another form of Behavioral Health services (e.g. face-to-face services) I will be recommended to be seen face-to-face at The REDI Clinic or see a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of behavioral health treatment, and that despite my efforts and the efforts of my behavioral health treatment provider(s), my condition may not be improve, and in some cases may even get worse.

- (4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

- (5) I understand that I have a right to access my medical information and copies of medical records in accordance with Wisconsin Law.

Patient’s Responsibilities
• I will review and sign The REDI Clinic “Telemedicine Patient Consent Form” and return to be placed in the patient’s medical record.

• I will supply contact information including my email, cell number and a phone/cell number of an emergency contact. My email address and cell number will be used to facilitate schedule and conducting telemedicine sessions. My emergency contact number will be used in situations in which your treatment provider is concerned for your safety.

• I will be required to give informed consent in writing for any prescribed medication. If a medication consent form is not available consent will be given by oral/verbal consent.

• I will not record or photograph any telemedicine sessions without written consent from my provider. I will not distribute and images or recording of my telemedicine session. I understand that my provider will not record any of our telemedicine sessions without my written consent.

• I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

• I will ensure that I am in a private and secure location while participating in telemedicine.

• I understand that it is each group member’s responsibility to maintain confidentiality of all group members during and outside of group sessions.

• I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telemedicine. 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 Wisconsin to be eligible for telemedicine services from The REDI Clinic of Wauwatosa, SC.

• I understand that my psychiatrist/therapist determines whether the condition being diagnosed and/or treated is appropriate for a telemedicine encounter.

• I understand that if the telemedicine session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to-face visit, or a second telemedicine visit.

• I can change my mind and stop using telemedicine at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.
Patient Consent to The Use of Telemedicine:

I hereby consent to engaging in telemedicine with THE REDI CLINIC OF WAUWATOSA, SC as part of my behavioral health evaluation and treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telemedicine.

Contact email: ________________________________

(This allows us to use your email to contact you with scheduling and connecting to telemedicine session)

Cell number: ________________________________

☐ OK to leave voice message ☐ OK to text

(This can be used to contact you for telehealth appointments or to connect with video conferencing applications such as Skype and FaceTime)

Emergency contact name and phone number: ________________________________

(My emergency contact number will be used in situations in which your treatment provider is concerned for your safety)

Name of Patient: * ________________________________

Signature of Patient or Representative: * ________________________________

Date: _____________

Name of Parent/Guardian (for minors): ________________________________

Signature of Parent/Guardian (for minors): ________________________________

Date: _____________

To be completed by The REDI Clinic Staff

Name of Witness: ________________________________

Signature of Witness: ________________________________

Date: _____________