FAMILY INSIGHT, P.C.
Enhancing the well-being of individuals and families℠

Telehealth Informed Consent

I/We,_____, consent to engage in telehealth and when allowed telephonic services, (e.g. psychotherapy, prescription refills, appointment scheduling, patient education, etc.); provided by Family Insight P.C. Telehealth services will occur through video communications via computer, tablet, webcam, and/or smart phone.

1) I/We have a right to know who is providing telehealth services and their credentials.

2) The Federal Confidentiality Rules (42 CFR Part 2) that protects the confidentiality of my personal health information also apply to telehealth services. As such, the information released by me during a telehealth session is generally considered confidential. There are both mandatory and permissive exceptions to this confidentiality including, but not limited to, reporting of child abuse, an expressed imminent harm to oneself or others, or as a part of a legal proceeding where information is requested by a court of law.

3) I/We accept responsibility for the confidentiality and privacy of the transmission medium and the environment from which I/We participate in services unless conducted at a Family Insight facility.

4) I/We understand it is my responsibility to ensure telehealth sessions are conducted in a private place.

5) I/We understand that there are risks and consequences in participating in telehealth including, but not limited to, the possibility, despite reasonable efforts on the part of Family Insight, that the transmission of information could be disrupted or distorted by technical failures.

6) I/We understand that the act of capturing photographs, audio, and/or video recordings by both provider and individuals present during the provision of services will be prohibited unless an expressed permission is granted in writing.

7) By signing this document, I/We understand that certain situations; including emergencies and crises are inappropriate for video/audio/computer-based services. If in crisis or in a situation of emergency, I/We should immediately call 911 or go to the nearest hospital or crisis facility. It is the role of the provider to determine whether the condition being diagnosed and/or treated is appropriate for a telehealth encounter.

By signing this document, have read and understand the information provided above with respect to telehealth services and have been informed that we may revoke our consent at any time.

Child/Client Signature:_____ Date Signed: _____

Parent/Guardian Signature:_____ Date Signed: _____

Family Insight Provider Signature:_____ Date Signed: _____