Telehealth Informed Consent
Complete Family Medicine

As a client receiving virtual visit services through telehealth technologies, I understand:

Telehealth is the delivery of services including, but not limited to, primary care, urgent care, individual, couple, or family psychotherapy using interactive technologies (use of audio, video and/or other electronic communications) between a practitioner and a patient who are not in the same physical location.

The laws and professional standards that apply to in-person services also apply to telehealth services.

Telehealth may include the transmission of patient-specific protected health information, medical history, clinical information, or documents by means of audio, video, or other telecommunications or electronic technology. It may also mean that my private health information may be transmitted to or from my mobile device via an “application” (abbreviated as “app”). Email is not guaranteed as a confidential form of communication and may be used for administrative purposes.

The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel.

The dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.

I will be informed of the identities of all parties present during the session. If applicable, I also agree that additional individuals will be part of the virtual visit, and we agree to be in the same physical place during video services and share one screen.

Video/Audio Recording:
I will not record, stream, or capture any of my telehealth communications.
Complete Family Medicine will not record, stream, or capture any of my telehealth communications.
The video call will be accessing my video camera and audio only when the call or meeting is occurring, and at no other time.

Limitations:
Regardless of the sophistication of today’s technology, some information my practitioner would ordinarily get in an in-person visit may not be available via electronic communication. I understand that such unclear, inadequate, or missing information could in some situations make it more difficult for my practitioner to understand my problems and make a complete and accurate diagnosis.

I further understand that I do not have to answer any question that I do not wish persons present to hear. It is my responsibility to maintain privacy on the patient end of communication. If my provider does not receive or perceive some information, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Risks of Technology:
These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft or unauthorized interception of personal information, and disruption of service due to technical difficulties.
I understand that telehealth is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.

Technology Requirements:
I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. I am using my own equipment to communicate.

Disruption of Service:
Should service be disrupted during a virtual visit, the provider will make a reasonable effort to resolve technical issues or call you via telephone to continue the session.

Emergency Protocol:
My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis. I will provide and/or my provider will confirm the address of my physical location in case emergency medical services are required.
The services provided are conducted from the Complete Family Medicine office. I certify that I am located in the state of Missouri.

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits. This document does not replace other agreements, contracts, or documentation of informed consent. I fully understand this consent and am signing it voluntarily.

Name (printed):_____ Date of Birth:_____

Signature:_____ Date:_____

Witness Name (printed):_____

Signature:_____ Date:_____