NORTHWEST MICHIGAN HEALTH SERVICES INC

Informed Consent for Telehealth/TeleDental Services

Today's Date: _____

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Purpose: Northwest Michigan Health Services, Inc. and the healthcare provider assigned to me will provide health care services through the use of live, two-way video (visual) and/or audio (sound) and other computer-based services.

I understand that the electronic services allow Provider to obtain information about my health status through electronic communications for the purpose of diagnosing and determining a treatment plan for certain non-emergency conditions.

I understand that the information provided or exchanged may be used for diagnosis; treatment plan development and review; and case management; and may include any or all of the following electronic communications: patient medical record documentation, live two-way video and audio files and transmission of images and other data.

Possible Risks: As with any use of technology, there are potential risks associated with the use of the electronic care services. I understand that these risks include, but may not be limited to, the following risks:

- Delays or errors in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- Information transmitted may not be sufficient to allow for appropriate medical decision making.
- Although precautions are taken to protect the confidentiality of information new security threats can develop. I understand that there may be other risks to the confidentiality and security of my personal information that neither Northwest Michigan Health Services nor I can anticipate at this time.

Patient Consent:

- I understand that the laws that protect privacy and confidentiality of health information also apply to telehealth, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.
- I understand that this consent will expire (365) days from the date of my signature. However, I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I do not have to use Telehealth Services; it is my choice to use electronic services.
- I also understand that the Provider will document the services I receive in my Northwest Michigan Health Services, Inc. electronic medical/dental record.
- I understand that no results can be guaranteed or assured.
- I understand that insurance companies and third-party payers, including Medicare and Medicaid, may not pay for electronic visits. If my insurance company or third-party payor does not pay for an electronic visit, I understand that I am responsible for paying for the Telehealth or Video Visit.
- I understand that the Provider may terminate a Telehealth Visit if the Provider determines that my condition requires immediate in-person care, or otherwise determines that a Telehealth Visit is not appropriate to meet my healthcare needs.
- I agree that Providers *may not* be able to prescribe certain types of medications, including controlled substances. I agree that any prescriptions I receive from an electronic visit will be used only by me, for my healthcare needs.

I have read this document carefully and understand the risks and benefits of the electronic services and wish to obtain services through electronic visits.

Signature:	**Patient/Guardian:**	**Date:**
	Print Guardian Name:	**Relationship:**