ASTRA BEHAVIORAL HEALTH, LLC

INFORMED CONSENT FOR TELEHEALTH SERVICES

PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:
Date of Birth:	Social Security Number:	
Phone Number:	E-Mail Address:	

INFORMATION

You are going to have a clinical encounter using telehealth technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

Expected Benefits:
•Improved access to care by enabling a patient to remain within the facility/home and obtain services from providers at distant sites.
• Patient remains closer to home where local healthcare providers can maintain continuity of care.
• Reduced need to travel for the patient or other provider.

The Process: You will be introduced to the provider and if applicable anyone else who is in the room with the provider. If you are unsure of what is happening, you may ask questions of the provider, anyone with the provider, or any staff in the room with you. If you are not comfortable with seeing a provider using telehealth technology, you may reject the use of telehealth and schedule a traditional face-to-face encounter at any time. Safety measures are being used to ensure telehealth is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks: There are potential risks associated with the use of telehealth which include, but may not be limited to:
• A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
• Technical problems may delay evaluation and treatment for encounters.
• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified if any security issues arise.

By Signing this Form, I understand the following:
1. I understand that I have the right to 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.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telehealth.
5. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.

I hereby authorize ASTRA BEHAVIORAL HEALTH to use telehealth in the course of my diagnosis and treatment.

Signature of patient (or authorized person) _____Date _____

If authorized signer, relationship to patient_____