NORTHWEST **DBT**

# INFORMED CONSENT FOR TELEMEDICINE SERVICES

PATIENT NAME _____

PROVIDER NAME _____

I understand that telemedicine (real-time audio/video teleconference session) is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to

Northwest DBT providing healthcare services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier and Northwest DBT will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayment, deductible or coinsurance that apply to my telemedicine visit. This may or may not be the same cost as face-to-face sessions and this may not be covered at all by insurance.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I can revoke my consent orally or in writing at any time by contacting my provider. As long as this consent is in force (has not been revoked) my provider may offer health care services to me via telemedicine without the need for me to sign another consent form.

I understand that Northwest DBT will access contact with me in specific situations (e.g. if I am temporarily not able to attend a face to face session) through a secure, HIPAA compliant electronic platform. I also understand that it is my responsibility to choose a location, a time, a network and a device that maintains my privacy and prevents interruption during a telehealth session.

Signature of patient _____
(or person authorized to sign for patient)

Date _____