CALLEN-LORDE

MRN: _____

CONSENT TO CLINICAL CARE VIA TELEHEALTH PLATFORM

First Name: Last Name:

Date of Birth:

Thank you for choosing Callen-Lorde for your health care services. We want you to understand your rights and responsibilities while receiving care from us. Please carefully review this form regarding our telehealth platform.

1. I agree to engage in telehealth services performed by Callen-Lorde's health care providers.
2. My health care provider has explained to me how the video conferencing technology will be used. I understand that the visit will not be the same as a direct, in-person patient/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth visit if either of us determine that the video conferencing connections are not adequate for a telehealth visit.
4. I have had the alternatives to telehealth visits explained to me, and am choosing to participate in a telehealth visits.
5. I understand I will be responsible for co-pays for telehealth visits according to what my insurance carrier pays.
6. I understand that my provider will not video or voice record my visit(s). However, my health care provider will retain a clinical record of my care.

I understand that I am responsible to ensure privacy and confidentiality during the telehealth visit and understand specific steps I can take to maintain privacy, such as conducting my visit in a private space. I understand that Callen-Lorde is not responsible for who may hear or see your health information at the place in which you choose to participate. I also understand that my insurer may not pay if I am not in one of the following sites, and I agree that I will participate in a telehealth service only if I am physically located in any of the following: a hospital, mental health facility, a physician office, adult care facility or my place of residence. If my payer does not pay because I am not physically located in one of the above, I am responsible for payment.

7. I understand that telehealth is not meant to replace emergency care, and if I am experiencing emergency symptoms, I will call 911 or go directly to the nearest emergency room.
8. I understand that I have the option to request interpretation services, at the time I schedule my appointment, if needed.

By signing this form I certify, warrant and confirm:

- That I have read or had this form read and/or had this form explained to me in full.
- That I fully understand its contents, including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature Date Time