CMCOUNSEL, INC

TELEHEALTH INFORMED CONSENT FORM

This form is intended to educate you and obtain your permission to participate in a Telehealth consultation.

DATE: _____ TIME: _____

Provider Name and Location: _____

PATIENT'S NAME: _____ DOB: _____

PATIENT E-MAIL ADDRESS: _____

INTRODUCTION

Telehealth utilizes interactive video conferencing that enables a CM Counsel provider at a remote location to provide treatment and/or consult my local healthcare provider in making decisions about the care provided to me. I understand that this consultation will not be the same as a direct behavioral healthcare visit due to the fact that I will not be in the same room as my therapist or psychiatrist. Telehealth will allow me to receive behavioral health care without the need to travel to the office during the times that would be difficult to do so.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of Teleheath. These risks include, but may not be limited to:

- In certain cases, information may not be sufficient to allow for medical decision making by your provider.
- Delays in treatment could occur due to interruptions and/or failures due to interruptions and/or failures of the video and/or audio equipment.
- Notwithstanding best efforts to protect patient information, security protocols could fail, causing a breach of privacy of personal medical information. However, every effort has been made to secure all medical records and confidential information. The company we utilize for our video software is medical grade and encrypted to the highest level.

RELEASE OF INFORMATION

All existing laws regarding access to your medical information and copies of your medical records apply to this Telehealth consultation. Additionally, dissemination of any information from this Telehealth interaction to other entities shall not occur without your written consent.

I understand that the session will not be videotaped or recorded by my behavioral healthcare provider and I agree to likewise not record the session using audio or visual technology.

FINANCIAL RESPONSIBILITY

In consideration for the Telehealth services rendered to me, I agree to pay the charges not covered by any third-party payer, including any deductible, copayment, coinsurance, or any charges not covered.

PROXY

If I have signed this consent agreement on behalf of a person who may be temporarily or permanently incompetent, unable to sign, or a minor, I represent that I have the authority to sign this consent agreement on behalf of this person. The use of the first person in this consent agreement shall include me, and the person for whom I am representing.

I have read and understand the information above regarding Telehealth, have discussed it with my provider or such assistants as may be designated, and all my questions have been answered. I hereby give my informed consent for the use of Telehealth in my treatment.

PATIENT SIGNUATURE: _____ Date: _____

If the patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason below:

☐ Minor ☐ Disoriented ☐ Incompetent

Witness Signature: _____ Date: _____

Please return completed form to info@cmcounsel.com or fax to an office:

Exton: 610.524.0787

Plymouth Meeting: 610.825-7130

King of Prussia: 484.231.8688