TELEHEALTH INFORMED CONSENT

____ I understand that telehealth involves the communication of my mental health information in an electronic or technology-assisted format.

____ I understand I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Michigan at the time of this service.

____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), and it is my responsibility to check with my insurance plan to determine coverage.

____ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

____ I agree that the information exchanged during my telehealth visit will be maintained by Venture Counseling Group involved in my care.

____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth.

____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

____ I agree that I have verified to my healthcare provider for my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice rom any claims I may have about the telehealth visit.

____ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the providers' office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement for electronic communication between Venture Counseling Group and myself or with whom I am parent or legal guardian.

______________________________	______________________________
Patient or Legal Representative Signature, Date/Time	Relationship to Patient
______________________________	______________________________
Print Patient or Legal Representative Name	Witness Signature, Date/Time