CONQUEST
HEALTH & WELLNESS

CONSENT FOR TELEHEALTH SERVICES

I, _____, consent to engage in telehealth services with a licensed clinical practitioner at Conquest Health & Wellness, LLC.

1. I understand that my health care provider wishes me to engage in telehealth services and that I am able to withdraw my consent at any time I wish.

2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider. I understand that Florida privacy laws protecting the confidentiality of protected health information (PHI) also applies to our engagement in telehealth services unless an exception to confidentiality applies as outlined in our informed consent.

3. I understand that telehealth is the practice of delivering clinical health care service via technology assisted media and/or electronic methods. This has potential benefits including easier access to care and the convenience of meeting from a location of my choosing

4. I understand there are potential risks to this technology, due to the limited ability to respond to a crisis and/or emergency, interruptions, unauthorized access/breaches in confidentiality, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand that there will be no recording (audio or video) of any of the online sessions by either party. All of the information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written consent except where the disclosure is permitted and/or required by federal and state law.

6. I understand that if I am experiencing an emergency, a crisis, suicidal/homicidal thoughts, and/or active psychotic symptoms that is unable to be resolved immediately and/or remotely, the clinical practitioner may determine that telehealth services may not be the most appropriate service at that moment and that a higher level of care is required.

7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

8. If technical difficulties and/or interruptions occur during a telehealth session, there may be a time where I may need to end the session and plan to restart. If unable to connect after more than 5 minutes, please call the practitioner directly to discuss continuation of services or potential need to reschedule.

9. In the case of an emergency, the clinical practitioner may have to contact the emergency contact listed in your medical record and/or notify the appropriate authorities.

10. **EMERGENCY PROTOCOL**

I understand that I must inform the clinical practitioner of the address/location of where I am at the beginning of each session. Local Emergency Contact must be listed in the event of an emergency.

Emergency Contact: _____ Phone: _____

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me

· That I fully understand its contents including the risks and benefits of the procedure(s).

· That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

CLIENT NAME: _____ **PRACTIONER:** _____

SIGNATURE: _____ **SIGNATURE:** _____

DATE: _____