gulfcoast BEHAVIORAL HEALTH

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Telehealth Consent Form

Patient Name: ________________________________ DOB: _____________

I understand that telehealth is the use of electronic technology for communication for the purpose of providing healthcare services.

I understand that Gulfcoast Behavioral Health is based in Florida and likewise uses telehealth to conduct a consultation with their patients.

I understand that with the use of telehealth, the interaction shall be done through real-time audio-video communication. Our office utilizes Doxy for all telehealth appointments.

I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPAA) also apply to telehealth.

I understand that I am responsible for any payments (deductibles, co-payments, co-insurances, self-pay rates) that apply to my telehealth appointment. It is the responsibility of the policy holder to verify telehealth is a covered benefit on his/her insurance policy. Should the insurance company not cover the service, I understand the balance will be my responsibility.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment; I have the right to privacy where it shall be necessary to seek my consent to disclose my information unless those that are permitted by law to disclose without the need of my consent.

By signing this form, I have read and understand the information provided above, my rights, and obligations regarding telehealth. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telehealth for psychiatric care.

____ ________________

Client Signature Date

____ ______________________________

Parent/Guardian Signature Witness