Kids In The Middle

Telemedicine Informed Consent Form

I (name)_____hereby consent to myself or my child (print client's name) _____to engage in telemedicine via Doxy.me, telephone, video, or any other electronic means with _____(therapist) as part of my treatment.

I understand that "telemedicine" includes health care delivery, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. Should I do so, I will not risk the loss or withdrawal of treatment benefits to which I would otherwise be entitled.

2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to any other entities shall not occur without my written consent.

3. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

4. I understand and agree not to use any electronic device, computer program, or other electronic means to video or audio record any contact between myself and/or my child and any Kids In The Middle staff while using Doxy.me, telephone, video, or other electronic device.

5. I also understand that there are inherent risks and other potential consequences from the use of telemedicine, including, but not limited to,the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information or treatment could be disrupted or distorted by technical failures; the transmission of my medical information or treatment could be interrupted or accessed by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

6. I understand that telemedicine-based services, treatment, and care may not be as complete as in-office services in some instances. I understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. in-office services), I will be referred to in-office services when or as needed. If such services are not possible, due to distance or hardship, a therapist who can provide such services will be referred.

7. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy treatment, and that despite my efforts and the efforts of my therapist, my condition may not immediately improve, and in some cases may even decline.

I have read and understand the information provided above. I have discussed any and all of my current questions with _____my therapist and have been answered to my satisfaction.

_____ _____

Signature of client/parent/guardian/conservator Date

_____ _____

If signed by other than client indicate relationship Date