PATHWAYS
SPECIALTY CLINIC
2219 Sawdust Rd #1004, The Woodlands TX 77380

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the purpose is to assess and/or treat my psychiatric condition and I will not be physically in the same room as my health care provider.
2. I will be notified of and my consent will be obtained for anyone other than my healthcare provider present in the room.
3. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
4. I understand that there are potential risks to using technology, including Poor picture/video quality, failure of equipment, service interruptions, interception, and technical difficulties.
5. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to follow up.
6. I understand Telehealth visits may lack the ability to access to all the information that might elicit in a face to face visit, which may lead to errors in clinical decision making.
7. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I may revoke my consent at any time by contacting Pathways Specialty clinic office. I also understand that my refusal will not affect my right to future care or treatment.
8. I understand that the laws that protect privacy and the confidentiality of Protected Health Information apply to telemedicine services.
9. I understand that my health care information may be shared with other individuals for scheduling and billing purposes and my insurance carrier will have access to my medical records for quality review/audit.
10. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

11. I understand that this document will become a part of my medical record.

By signing this form, I attest that I,

(1) have personally read this form (or had it explained to me) and fully understand and agree to its contents;

(2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand;

(3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

Witness signature Date