intuition wellness center
LEARN. GROW. THRIVE.

5675 N Oracle Rd, Suite 3101
Tucson, AZ 85704
Phone: 520.333.3320
www.intuitionwellness.com

Telehealth Consent Form

PURPOSE: *The purpose of this consent form is to obtain your consent to participate in treatment and/or consultation, supervision using telehealth technology.*

NATURE OF TELEHEALTH SESSION: *The telehealth sessions will be much like services provided in-person, in that details of your or your child's medical, psychiatric, trauma, social, family, developmental, academic, occupational, and legal histories as well as current stressors and symptoms may be discussed.*

BENEFITS: *The benefits of telehealth sessions are:*

a. *You may not need to travel to the appointment location.*
b. *You have has access to a specialist through this appointment.*

RISKS: *I understand there are potential risks with this technology:*

a. *The video connection may not work or may stop working during the session.*
b. *The video picture or information transmitted may not be clear enough to be useful for the session.*
c. *Privacy cannot be guaranteed when the client is not using telehealth in a private location.*
d. *Despite best efforts to ensure high encryption and secure technology, there is always a risk that the transmission may be breached and accessed by unauthorized persons.*
e. *You may be required to go to the location of the consulting provider if it is felt that the information obtained via telehealth was not sufficient.*
f. *Your insurance may not cover sessions provided via telehealth.*

PROFESSIONAL RECORDS: *All existing laws regarding your access to medical information and copies of your medical records apply to telehealth services. The information about professional records outlined in the general Consent to Treatment applies to telehealth services. Telehealth sessions will not be recorded nor stored. Telehealth sessions will be documented with progress notes just as they are with face-to-face sessions.*

CONFIDENTIALITY: *Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth session, and all existing confidentiality protections under federal and Arizona state law apply to information disclosed during this telehealth session. The information about confidentiality outlined in the general Consent to Treatment applies to telehealth services. Telehealth communication at Doxy.Me is HIPAA compliant (meaning it is encrypted as required by law).*

RIGHTS: *You may withhold or withdraw consent to the telehealth sessions at any time without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.*

***DISPUTES**: You agree that any dispute arising from the telehealth session will be resolved in Arizona, and that Arizona law shall apply to all disputes.*

***PAYMENT FOR SERVICES**: Payments for telehealth must be made prior to the time of each session. Insurance companies may/may not pay for telehealth sessions depending on your specific plan. You have the option of paying with credit card over the phone or with a previous credit card on file. Current fees for telehealth are the same as for in-office treatment.*

***CANCELLATION POLICY**: Telehealth sessions cancelled without providing a 24 hour notice will be billed in-full.*

Client's and/or guardian's signature below acknowledges that:

- *Your health care provider has discussed with you the information provided above.*
- *You have had the opportunity to ask questions about the information presented on this form and the telehealth session. All your questions have been answered.*
- *You understand the written information provided above.*
- *You have received and reviewed a copy of Intuition Wellness Center, PLLC privacy practices notice.*
- *You understand the limits of confidentiality.*
- *You have read and understand the risks, consequences, and benefits of telehealth.*
- *This consent is voluntary and you may revoke your consent in writing at any time.*

Client Name	Signature of Client	Date

Guardian Name	Signature of Guardian	Date