Psychological Care Associates
A Division of Child & Family Psychological Services, PLLC

Administrative Office:
Psychological Care Associates
12 Alfred Street, Suite 200
Woburn, MA 01801-1915

Offices throughout Eastern Massachusetts
Tel: (781) 646-0500
Fax: (781) 646-7130
https://www.psycare.info

Informed Consent for Telehealth-Based Healthcare Services

Patient Name: _____

DOB: _____

Introduction

CFPS practitioners often use of Telehealth and related technologies to facilitate the delivery of healthcare services. Telehealth involves the use of electronic communications to enable health care providers and patients at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include psychiatrists, psychologists, nurse practitioners, therapists, primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may, but not necessarily, include any of the following: medical images, instant messaging, chat, telephone and/or email conversations, patient medical records, live two-way audio and video, and output data from medical devices and sound and video files.

Expected Benefits

- Improved access to medical care by enabling a patient to remain at a remote site while the practitioner obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation, treatment and management.
- Obtaining expertise of a distant specialist.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment. In the event that there is an equipment or technological failure during a Telehealth encounter, you should call your provider to receive follow-up or ongoing care.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- In the event of adverse events or unexpected reaction to treatment that may occur during or after your Telehealth encounter, you should follow up with your primary care physician or emergency room, if applicable, or you may call your practitioner for any nonurgent issues. Telephone calls will be returned within 72 hours.

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By Signing this form, I understand the following:

1. I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.
2. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My practitioner has explained the alternatives to my satisfaction.
3. My practitioner must clearly disclose his/her identity, including information such as the practitioner's name, address, contact information, and medical licensing credentials.
4. CFPS will not allow any other people to observe or participate in the Telehealth encounter without my knowledge or advance consent.
5. CFPS will not make recordings of any video or telephone encounters about me without my advance consent.
6. I understand that I am responsible for securing a quiet, comfortable, and private space suitable for telehealth services. I am also responsible for supplying sufficient technological resources, knowledge of how to use the necessary software and equipment, and time to set up for, and participate in, telehealth services.
7. I agree not to record, save, publish, disseminate, or electronically transmit any data, images, video, audio, and/or any other aspect of the telehealth and/or videoconferencing service.
8. I understand that because the healthcare provider may be distant and/or unfamiliar with the local area, they may be unable to provide adequate emergency assistance. In case of a crisis or emergency situation arising in which someone is in danger, I agree to take whatever precautions and steps necessary to maintain safety, including calling 911 and/or going to the nearest emergency room.
9. I understand that laws and regulations vary in each state and that the provider may not be able to provide telehealth services when I am in certain states. I understand the laws pertaining to limits of confidentiality, mandated reporting, duty to warn, and involuntary hospitalization also vary by jurisdiction at time of service. I agree to specifically inform the provider what state I will be in at the time of service when the appointment is scheduled.
10. I understand the CFPS/IBA clinicians may not be licensed in the state in which I am participating in services, if such states do not require a licensure, or allow for a temporary licensure or temporary practice. Likewise, I understand the number of visits the clinician can provide while I am outside of Massachusetts may be limited depending on what state I am in at the time of the service amongst other factors.
11. I may request a copy of my medical information and/or that my medical information be sent to my primary care provider or other healthcare provider, if applicable.
12. My practitioner must provide appropriate follow-up care or recommend follow-up care as necessary.
13. I have the right to know what personal data may be gathered about me and by whom.
14. I have been informed about when online communication should not take the place of a face-to-face interaction with a practitioner.

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15. I have the right to be provided meaningful opportunities to give feedback about any concerns I may have about my care and that CFPS must review and respond to those concerns in a timely and appropriate manner.
16. CFPS must obtain my express consent before forwarding any of my identifiable information to a third party other than in accordance with HIPAA and other applicable laws.
17. I must verify my identity and location prior to initiating a Telehealth encounter.
18. Telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
19. I agree to hold harmless my practitioner for delays in evaluation or for information lost due to such technical failures.
20. It is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
21. I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.
22. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Patient Consent To The Use Of Telehealth

I have read and understand the information provided above regarding Telehealth, have discussed it with my practitioner or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of Telehealth in my medical care.

I hereby authorize CFPS practitioners to use Telehealth in the course of my diagnosis and treatment.

Signature: _____

Date: _____

Name of Patient Representative, if applicable: _____

Description of Patient Representative's Relationship to Patient, if applicable:

_____