Club Spectrum ABA
Orlando, FL
Phone: (407) 369-3788
coribonfilio@clubspectrumaba.com

Telehealth Consent Form

1. I authorize Club Spectrum ABA to allow me/the patient to participate in a telehealth (videoconferencing) service _____
2. The type of service to be provided by via telehealth is: supervision, parent training, etc. as approved by insurance.
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth healthcare provider.
4. My/the patient's provider has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a clinician in-person. The attendant risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.
6. I understand that the telehealth session will not be audio or video recorded at any time, unless I have been previously notified.
7. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:

a. Omission of specific details of my/the patient's medical history that are personally sensitive, or
b. Asking non-clinical personnel to leave the telehealth room at any time if not mandated for safety concerns, or
c. Termination of the service at any time.

9. When the telehealth service is being used during an emergency, I understand that it is the

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responsibility of the telehealth provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.

10. It is the responsibility of the telehealth provider to conclude the service upon termination of the video conference connection.
11. I/the patient understand(s) that my/the patient's insurance will be billed by both the local healthcare provider **and** the telehealth healthcare provider for telehealth services. I/the patient understand(s) that if my insurance does not cover telehealth services I/the patient will be billed directly by both the local healthcare provider **and** the telehealth healthcare provider for the provision of telehealth services.
12. My/the patient's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I/the patient acknowledge the telehealth program's no-show policy which states that I/the patient will be discharged from the telehealth program if I/the patient no-show for 2, consecutive telehealth appointments, without prior contact to the scheduling staff.
15. I confirm that I have read and fully understand the above and the *Telehealth: What to Expect Form* provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian Signature:*

_____

Print Name:

_____

Date:

_____

* The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

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I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____

Provider's Signature Date