Provider: Greg Smith
Psychiatric Nurse Practitioner, MS, APRN, PMHNP
Email: greg@innerself-care.com
Phone: (864) 618-2817

Patient Name: ____

Informed Consent for Telehealth Services

- I understand that Telehealth is my provider's primary source of treatment

- I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

- I understand that telehealth treatment can present the opportunity for technical difficulties, and should technical issues occur, I will **email** my provider to inform him/her of the issue and agree on how to proceed
- If my provider is experiencing technical issues, your provider will reach out via **email** and you both will agree how to proceed (rescheduling, phone conversation, etc.).
- I understand that if I am experiencing technical difficulties, and fail to reach out to my provider **via email** to make other arrangements, I will be responsible for a $99 Missed Appointment Fee.

•I understand that the telehealth visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telehealth.
- I understand that I will be responsible for any additional fees that apply to my telehealth visit. - I understand that telehealth can create breaches of privacy if I am in the presence of others. My provider will not be responsible for any branches of privacy created by me to which he/she has no control over.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, and if I choose to withdraw my telehealth consent, I will not be able to receive treatment since telehealth is my provider's primary source of treatment.
- I understand that by signing this form that I am consenting to receive health care services via telehealth
- I understand that I am giving my provider consent to email and text me my appointment link to access virtual appointments.
- Appointment Links will be sent to the email address provided by the patient

Patient Email Address: ____

Patient Name (Print): ______________________________
Patient Signature: ________________________________
Date: ____