THE UNIVERSITY OF ALABAMA® | Student Health Center *and* Pharmacy

TELEMEDICINE INFORMED CONSENT

I _____ [name of Patient] hereby consent to engaging in telemedicine with _____ [name of Psychiatry Provider] as part of my psychiatric treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Alabama or outside of Alabama.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatry provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychiatry provider believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychiatry provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry/psychotherapy, and that despite my efforts and the efforts of my psychiatry provider, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Alabama law.

I have read and understand the information provided above. I have discussed it with my psychiatry provider, and all my questions have been answered to my satisfaction.

_____ _____

Signature of patient Date

Created: 08/2020

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Billing for Non-Covered Services

Or

Covered services that the patient has opted out of submitting to the health insurance carrier

Patient Name	CWID	Date

It is our goal to provide you the best care possible. There are services or durable medical equipment and supplies that may be provided for the treatment of your condition, and deemed necessary by your provider, that may not be covered by your health benefits insurance contract. You are expected to pay for those services in full.

Additionally, if you have requested services and chosen to not have the provided services submitted to your health insurance carrier for payment, you are expected to pay for those services in full.

These charges will be billed to your student receivables account.

*Services that may not be covered include, but are not limited to:

Durable Medical Equipment and Supplies

Visits to screen for Sexually Transmittable Infections

Women's Health

Behavioral Health

Immunizations

Allergy Treatment

If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. You can also contact your insurer' Customer Service Department at the number on the back of you ID card. Thank you for understanding.

Consent obtained by: _____

I have read the above policy and agree to pay for the services not covered by my health benefits insurance contract, or not submitted to my health insurance carrier at my request, as indicated by my signature.

Signature of Patient (no initials please): _____

Revised: February 2017