Wellsmith Integrative Mental Health, PLLC

Telemedicine Informed Consent

Patients MUST be located in the state of MASSACHUSETTS for all telehealth appointments due to medical licensure laws.

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

I understand that I may opt out of the telehealth visit at any time. However, because this office only provides telehealth services, I understand that if I opt out of telehealth, I will not be able to receive future care here.

I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Massachusetts at the time of service. I also understand that my treatments are designed to be by appointment only, and while the provider is available via email between appointments, such communications should be limited to non-urgent questions or requests, which will be responded to within two business days. If multiple questions or concerns arise between visits, a separate follow-up appointment will likely need to be scheduled.

I understand that telehealth billing information is collected in the same manner as a regular office visit. I am aware that the fee will be due at the time of service and that Wellsmith Integrative Mental Health, PLLC does not accept insurance or participate in any insurance plans, including Medicare. Accordingly, I acknowledge that Medicare will not reimburse me for these services. I further understand that potential reimbursement from a private or company-sponsored health insurance plan will be governed by my insurance carrier(s), and it is my responsibility to check with my insurance plan to determine coverage.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider. I also understand that my healthcare provider serves in a consultative fashion and that engagement in his or her services occurs with the understanding that I am in active regular medical treatment with a primary care physician who conducts physical examinations and routine health maintenance including monitoring of my weight and vital signs (e.g., blood pressure, pulse, respiratory weight). I agree to allow my healthcare provider to be in communication with my primary care physician if it is deemed by my healthcare provider to be clinically indicated.

I understand that electronic communication cannot be used for emergencies or time- sensitive matters. In the event of an emergency, I agree to contact my primary care provider, call 911, or present to the nearest emergency room.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, dietary and other lifestyle interventions, an in-office evaluation by my primary care provider, or referral to or follow-up with a specialist.

I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided. Accordingly, to the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

By signing this "INFORMED CONSENT FOR TELEMEDICINE SERVICES" form, I hereby give informed consent for the use of telemedicine in my medical care under the terms and conditions described herein and verify that I have:

1. Read the whole consent form and fully understand the information provided above regarding telemedicine, including its potential benefits, potential risks, and any practical alternatives;
2. I have had the opportunity to fully discuss the information contained herein with Dr. Ivkovic and have had all of my questions answered to my reasonable satisfaction to make a voluntary, informed decision regarding the use of telemedicine services; and
3. I will be located in the State of Massachusetts during the performance of telemedicine services

PATIENT SIGNATURE: _____

Patient's Printed Name: _____

DATE _____

Revised: 10/12/22