WellPower

Consent for Telehealth Services

Legal Name (please print) | Date of Birth | WellPower ID#

Please read and complete this form to consent to telehealth services. This *Consent for Telehealth Services* is in addition to WellPower's general *Consent for Services* and does not replace or change its terms.

Explanation of Telehealth. Telehealth involves the use of communication technologies to enable WellPower medical providers and clinicians to connect with individuals through electronic means while the service provider and the person receiving services are at different locations. Telehealth includes the practice of behavioral health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. WellPower is offering telehealth as a way of expanding access to services.

I understand and agree to the following:

1. The laws that protect the confidentiality of my health information also apply to telehealth. There are some exceptions to this general rule of confidentiality including, but not limited to: danger to myself or others; abuse or neglect of child, elder, or at-risk adult; or grave disability.
2. The communication technologies WellPower uses for telehealth incorporate a variety of security measures to protect the confidentiality of information that is transmitted.
3. Despite reasonable efforts on behalf of WellPower and my medical provider or clinician, there are risks to telehealth services including, but not limited to, disruption or distortion of communication because of technology failures, or unauthorized persons interrupting or accessing communication. In case of technology failure, I may contact WellPower by phone to coordinate alternative methods of service delivery.
4. Telehealth may be experienced differently than in-person services. If my medical provider or clinician thinks I would be better served by another form of service delivery, such as in-person, I may be referred to a medical provider or clinician in my geographic area that can provide services or offered an in-person appointment at a WellPower facility.
5. I can withdraw my consent for telehealth services at any time without affecting my ability to receive other WellPower services, now or in the future.
6. I cannot record telehealth sessions and my medical provider or clinician will not record session without my written authorization. Information shared during telehealth sessions is confidential and cannot be disclosed without my written authorization unless a disclosure is required or permitted by law.
7. Other people may be in the room with my medical provider or clinician, such as a scribe to take notes or someone to provide technology support. I will be informed of their presence, and I have the right to ask that they leave the session. Also, my health information may be shared with others authorized by WellPower for scheduling or billing purposes. The above-mentioned people will maintain confidentiality unless a disclosure is required or permitted by law.
8. I have the right to access my medical information and copies of my medical records in accordance with federal law and the laws of the State of Colorado.
9. WellPower will bill my health insurance for telehealth services, as appropriate. I am responsible for all charges for telehealth services not covered by insurance.
10. In a **crisis** or **emergency** situation, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

By signing below, I acknowledge that I have read and understand this consent form; all of my questions regarding telehealth services have been answered to my satisfaction; I accept the risks and possible charges associated with telehealth services; and I consent to telehealth services.

X _____ _____

Signature of individual or personal representative | Signature Date

_____ _____

Name of Personal Representative (if applicable) | Relationship