PATHFINDERS
COUNSELING AND CONSULTING

## Telemedicine/Telehealth Informed Consent

Telemedicine/Telehealth services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a Telemedicine/Telehealth visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the Telemedicine/Telehealth visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a Telemedicine/Telehealth visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Pathfinders Clinic at 210-202-0100.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to Telemedicine/Telehealth services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my Telemedicine/Telehealth visit.
   c. I understand that health plan payment policies for Telemedicine/Telehealth visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to Telemedicine/Telehealth visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my Telemedicine/Telehealth visit(s).

_____ _____

Patient/Parent/Guardian Printed Name | Patient/Parent/Guardian Signature

_____ _____

Witness Signature | Date

## NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board**
**Attention: Investigations**
**333 Guadalupe, Tower 3, Suite 610**
**P.O. Box 2018, MC-263**
**Austin, Texas 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number:

**1-800-201-9353**

For more information, please visit our website at

**www.tmb.state.tx.us.**

**Texas State Board of Examiners of Psychologists**
**333 Guadalupe Street**
**Tower 2, Room 450**
**Austin, Texas 78701**

Tel. (512) 305-7700 *
1-800-821-3205 24-hour, toll-free complaint system
Fax (512) 305-7701