NEW STORY BEHAVIORAL HEALTH
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NEW STORY
BEHAVIORAL HEALTH

WITH CURT THOMPSON, MD

STATEMENT OF CONSENT FOR TELEHEALTH

Patient Name (printed): _____

I, the undersigned agree to participate in video conference consultation with _____ (clinician name), a mental health care provider ("provider"). This means that I authorize information related to my medical and mental health and health care to be electronically transmitted in the form of images and data through an interactive video connection to and from the above named provider, other persons involved in my health care, and the staff operating the consultation equipment.

My health care provider has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My health care provider has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology. In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically. Some information my provider would ordinarily get in face-to-face consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to touch me or render any emergency assistance.

I understand that telehealth consultation(s) are a new form of treatment, in an area not yet fully validated by research, and that they have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized are the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

I authorize the release of any information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, birth date, and clinical or medical record information.

I understand that at any time, the consultation(s) can be discontinued either by me, by my designee, or my health care providers. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate in the consultation(s) will not affect my continued treatment, and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand that, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to proper authorities information suggesting that I have engaged in behaviors that endanger others.

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of forgoing treatment. I understand that the telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the consultation's effectiveness.

This agreement shall be governed by the laws of the Commonwealth of Virginia. Any dispute arising from, or relating to this agreement and the service provided shall be brought in a court within the Commonwealth of Virginia.

I am aware that my provider may contact proper authorities in case of an emergency. I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telehealth consultation. Instead, I will seek care immediately through my own local health care provider, at the nearest hospital emergency department, or by calling 911.

These are the names and telephone numbers of my local emergency contacts
(including trusted family member, or friend; local physician; crisis hotline):

Name	Telephone Number	Name	Telephone Number
Name	Telephone Number		

I release and discharge New Story Behavioral Health, its affiliates, agents, employees and my provider and his or her designees from any liability in connection with my participation in remote consultation(s).

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telehealth videoconference consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Signature	Date