Randi Most, Ph.D., ABN
Board Certified Neuropsychologist

TELEHEALTH INFORMED CONSENT

As a patient receiving neuropsychological services through telehealth methods, I understand that such service is provided by technology (including but not limited to video, phone, text, and email) and in part or in whole does not involve direct, face to face communication.

TECHNOLOGY/EQUIPMENT: If a remote video platform is utilized, then I understand that I will need an installed and working webcam and speakers or headphones. I understand that I will receive an e-mail with a link to open the remote video program and if not previously downloaded, there may be some time necessary to download the program onto my computer before it starts. I understand I will need a PC or Mac or iPad; a Chromebook or iPhone or other cellular phone or other internet enabled device may not work and may not be appropriate.

The quality of the communication depends upon the sophistication and reliability of the telehealth medium used based upon my own internet connection, my provider's internet connection, the program itself, or the program's internet cloud based system. I understand that there could be some miscommunication or lack of communication as a result of technological limitations or unreliability inherent within my or my provider's internet service and platform utilized which are not under the control of myself or my provider.

In the event of disruption of the telehealth service or in the event of an emergency, or for other routine or administrative reasons, it may be necessary to communicate by other means such as direct telephone communication. The following phone numbers will be set up as a backup in the event the telehealth platform cannot be utilized from the start of the scheduled session or at any time after the session begins:

Provider phone: 904-703-3814 or 904-223-5007

Patient or Family Member phone: _____

CONFIDENTIALITY: I understand that staff be may present during the session to initiate the connection or if there is a problem only to assure reliable operation of the telehealth system. Such staff will maintain confidentiality of any information under contractual arrangements and/or Federal law and/or State law.

While telehealth services allow for greater convenience in service delivery, there are risks in transmitting information over the internet that include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be under the control of either my neuropsychological services provider or myself.

ENVIRONMENT: ***It is my responsibility to maintain privacy and a controlled quiet environment on my end of the telehealth communication*** which means that there should be not any disruption such as from children, animals, family members, other individuals, or other environmental disruptions (e.g., landscaping, traffic, telephone calls or ringtones, etc.). In the event that such disruption occurs and is deemed by my provider to compromise the quality of the telehealth services she is attempting to deliver, I understand that, at my provider's sole discretion, the session will be terminated .

INSURANCE: I understand that telehealth services may or may not be a covered benefit under my insurance plan; if they are covered, any plan co-pay and deductible will apply. The same No-Show and Cancellation policies previously signed and agreed to at the start of treatment remain in effect.

TESTING: If my telehealth session is for the purpose of psychological or neuropsychological evaluation involving testing procedures, I understand that the administration of such procedures via telehealth may not meet standards typically required. As a result, this may decrease the accuracy of test scores, interpretation of test scores, conclusions, diagnoses, and recommendations. Any limitations as to my clinician's confidence in the results will be documented within the written report. I understand I have a right to forgo such psychological or neuropsychological evaluation and schedule an appointment at a later time when my clinician is able to provide the test administration within the office.

I understand that I may dispute any results on the basis of the non-standardized telehealth test administration and such dispute shall be provided in writing and entered into the formal record and attached to the written report as per federal HIPAA law. However, if a re-evaluation is requested or required with test administration within the office of my clinician, then the full fee for another evaluation will be required which may or may not be covered by my insurance plan.

I hereby attest that any test forms provided to me in the course of the telehealth test administration shall be returned via regular mail via sealed envelope without any copies made or other documentation of the content of the test forms. If I am provided test forms in any electronic format, I hereby attest that I shall destroy or permanently delete these electronic forms without creating any type of copy or documentation as to the content of the forms. **I hereby attest that I will not make any copy or recording of any material provided on my computer screen/monitor** including the creation of a screenshot or copying and pasting of any information provided on screen.

Any breach of the above conditions will result in the immediate termination of the telehealth psychological or neuropsychological evaluation; it will also be documented within the report generated up to and including providing statements that the entire report is invalidated and cannot be used for diagnostic or treatment planning purposes. If such a breach occurs and any portion or all of the evaluation is terminated or determined to be invalid, then any and all fees provided for payment of the evaluation shall be forfeit and nonrefundable.

DOCUMENTATION: I understand that the documentation my provider writes in relation to any telehealth session will be created and stored in the same EHR system as any note created from a face-to-face appointment/session. Such documentation falls under the same legal, professional, and contractual guidelines as any document stored as the result of a face-to-face appointment/session. No different than any documentation in my record, I understand that I have access to information resulting from the telehealth service to the extent required by State and Federal law.

RIGHT TO WITHDRAW CONSENT: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time so long as it is provided in writing in accordance with State and/or Federal law without affecting my right to future care or treatment. As long as this consent is in force, telehealth services may be provided to me without the need to sign another consent form.

COMPLIANCE WITH LAW: I understand that telehealth services provided to me must comply with State and Federal (HIPAA) law and I acknowledge that I am aware of such laws. I understand that the reporting requirements (e.g., to law enforcement or a state agency) which may be mandatory under State law are no different than if the service was provided face-to-face as per the Consent Form I originally signed for service.

RECORDING: According to Florida law and under penalty of Florida law, I understand that there will be **NO** recording of any video or audio information from the telehealth session by myself or my provider or any other participant in my telehealth session(s) without the mutual signed consent of myself and my provider (and any other participant as applicable).

I understand that if I do record any portion of the video or audio information without mutual consent, the telehealth session will immediately be terminated, all future treatment sessions of any kind will be canceled/terminated, and I will be discharged from my provider and with all fees forfeited.

- I have read or had this form read and/or had this form explained to me.
- I have been given ample opportunity to ask questions and my questions have been answered.
- The risks, benefits and any practical alternatives have been discussed in language I understand.
- The alternatives to telehealth consultation have been explained to me, and I am choosing voluntarily to participate in a telehealth consultation.

This document does not replace other agreements, contracts, or documentation of informed consent.

_____ _____

Print Patient Name Print Legal Guardian Name (if applicable)

_____ _____

Signature of Patient or Legal Guardian Date