Family Service Madison

By signing this form, I understand and agree with the following:

1. Telehealth is the delivery of services using interactive technologies (audio, video, or other electronic communication) between a practitioner and a client/patient who are not in the same physical location.

2. The interactive technologies used in Telehealth services incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel.

3. The laws that protect the privacy and confidentiality of health, mental health, and early intervention also apply to telehealth sessions and tele-intervention. Information obtained during Telehealth that identifies me or my child will not be given to anyone outside of Family Service Madison without my consent except for the purposes of treatment, payment, and healthcare operations.

4. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

5. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery following HIPAA compliance laws.

6. As with any internet-based communication, I understand that there is a slight risk of security breach. However, I believe that the potential benefits of Telehealth outweigh this risk.

7. I agree to only have Telehealth services when I am using a secure internet connection.

8. I understand that my email address is required for this service, and I will inform Family Service Madison of any change to my email address.

9. I have the right to withhold or withdraw my consent to the use of Telehealth at any time. Withdrawing my consent will not affect any future services.

10. This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. I acknowledge that there are benefits and limitations to this service.

11. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today and modify our plan as needed.

12. I acknowledge that much of my communication with Family Service Madison will be through email. I will check my email regularly, including emails for Telehealth invites for my sessions from HIPAA compliant **Zoom Healthcare** and HIPAA compliant **Microsoft Teams**.

13. I acknowledge that part of the Telehealth system with Family Service Madison will be to receive invoices for any payments that need to be made via email from PayPal. I understand that my payments can be made directly from this PayPal invoice or on Family Service Madison's website (https://fsmad.org/index.php/pay-your-bill/).

14. I understand that part of the Telehealth system with Family Service Madison will be to receive automated appointment reminders via email (when applicable).

15. I have read and understand the information provided above regarding Telehealth, and all of my questions have been answered to my satisfaction.

I hereby consent to the use of Telehealth by Family Service Madison.

Name of Client: _____

Name of Parent/Guardian: _____

Signature: _____

Date: _____