TRUENORTH PSYCHIATRIC NURSING CORP

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TELEHEALTH CONSENT

Informed Consent for Telehealth Services

California telehealth consent • Please review before your first telehealth visit.

WHAT IS TELEHEALTH?

Telehealth is a way of delivering healthcare through information and communication technologies when the patient and healthcare provider are in different locations. TrueNorth may use secure video, audio, patient-portal, or other legally permitted technology for psychiatric evaluation, consultation, treatment, medication management, education, care coordination, and follow-up, when clinically appropriate.

YOUR CHOICE & CONSENT

Before providing care by telehealth, your provider will explain the use of telehealth and obtain your verbal or written consent. Your consent will be documented in your medical record.

- Participation in telehealth is voluntary.
- You may withhold or withdraw consent to telehealth at any time.
- Choosing telehealth does not prevent you from receiving in-person healthcare during your course of treatment.
- Your provider may determine that telehealth is not appropriate for a particular clinical situation and may recommend an in-person examination, another healthcare professional, urgent care, or a higher level of care.

BENEFITS & LIMITATIONS

Potential benefits include improved access to psychiatric care, convenience, continuity of treatment, and reduced travel. Telehealth also has limitations and risks. These may include technology failure or interruption, delays, reduced ability to perform a physical examination, limitations in observing certain clinical findings, and privacy or security risks despite reasonable safeguards. If the connection is inadequate for safe or effective care, the visit may need to be rescheduled, continued by another appropriate method, or converted to an in-person evaluation.

PRIVACY & CONFIDENTIALITY

Federal and California laws governing confidentiality, privacy, professional responsibility, and access to health information also apply to telehealth. Reasonable administrative, technical, and physical safeguards are used to protect health information. However, no electronic communication system can be guaranteed to be completely secure.

To help protect your privacy, you are encouraged to participate from a private location and use a secure device and network. Do not record a telehealth visit unless you have first discussed recording with your provider and all applicable requirements have been satisfied. Information transmitted as part of telehealth may become part of your medical record.

LOCATION & IDENTITY DURING VISITS

For safe telehealth care, TrueNorth may verify your identity, current physical location, and a callback number at the start of a visit. Please tell your provider if you are outside California. The provider must comply with licensing and practice requirements applicable to the location where you are physically present, and a visit may not be able to proceed.

EMERGENCIES

TrueNorth is an outpatient psychiatric practice and telehealth is not an emergency service. Telehealth messages, email, texts, and routine office communications are not continuously monitored. If you believe you are experiencing an immediate medical or psychiatric emergency or are in immediate danger, seek emergency assistance in your current location rather than waiting for a response from TrueNorth.

PAYMENT & INSURANCE

When insurance is used, TrueNorth may bill eligible telehealth services according to your health plan and applicable law. Copayments, coinsurance, deductibles, and non-covered services may remain your responsibility. Coverage verification is not a guarantee of payment. Self-pay telehealth services are subject to TrueNorth's Financial Policy.

PATIENT CONSENT

I have read or had this form explained to me. I understand the nature of telehealth, including its potential benefits, limitations, alternatives, and privacy considerations. I have had an opportunity to ask questions. I voluntarily consent to receive healthcare services from TrueNorth through telehealth when clinically appropriate.

☐ I consent to the use of telehealth services. ☐ I do not consent to telehealth services.

Patient Name: _____ Date of Birth: _____

Patient / Parent / Legal Representative Signature: _____