LifeBalance counseling

1305 Remington Rd, Suite U
Schaumburg, IL 60173
888.234.7628
info@lbcounseling.com

INFORMED CONSENT FOR TELEHEALTH SERVICES

PATIENT NAME: _____ LOCATION OF PATIENT:_____	DATE OF BIRTH: _____	PAYMENT AMOUNT: _____
COUNSELOR'S NAME: _____ LOCATION: _____		DATE CONSENT DISCUSSED: _____

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby give consent to the counselors of Life Balance Counseling, Inc. to provide health care services to me via telehealth.

My health care provider has explained to me how the HIPPA compliant video conferencing technology (doxy.me) will be used during telehealth services. I understand that this counseling session will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, your insurance carrier will have access to your medical records for quality review/audit. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit and agree to pay in full at the beginning of the session.

I understand that the paperwork I signed with Life Balance Counseling, Inc., including; initial intake paperwork, HIPPA and privacy policy, signed release of information, and rates/fees apply to telehealth services. 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, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Life Balance Counseling, Inc. at 888.234.7628 or info@lbcounseling.com. As long as this consent is in force (has not been revoked) Life Balance Counseling may provide health care services to me via telehealth without the need for me to sign another consent form.

Signature of Patient (or authorized person) _____ Date: _____

If authorized signer, relationship to patient: _____ Date:_____