TELEHEALTH INFORMED CONSENT

Patient Name: **DOB**: **Claim Number**:

☐ **Provider: Dr.Figueroa, M.D.** ☐ **Maried Gutierrez, LMHC**

This form seeks the client/patient's consent to engage in telemedicine with the physician and/or the mental health therapist named above.

If you are scheduled for an IME or Evaluation ONLY, please make sure to mark the red box and all other boxes.
If you are scheduled for Evaluation and Treatment, please mark the boxes with an asterisk (*) ONLY.

* ☐ **I understand that this is an Independent Psychiatric Medical Evaluation. I am aware that this evaluation does not involve the provision of medical treatment or advice. No treating physician/patient relationship will be established during the Independent Psychiatric Medical Evaluation (IME).**

* ☐ I understand that telemedicine refers to the utilization of communication technologies, including the Internet, by healthcare providers to deliver healthcare services via audio and video, irrespective of the geographical location.

* ☐ I understand the benefits and limitations of telemedicine. understand the limitations of telemedicine, where it cannot be fully equal to the face-to-face mode of treatment, and that such delays may occur due to intermittent communication, which the telemedicine service provider has no control over.

* ☐ I understand that there are state laws that help protect my privacy by standardizing confidentiality and information security that apply to telehealth and telemedicine consultations, such as HIPAA. However, if my insurance provider needs access to my medical information, I hereby grant my insurance provider and or its representative access to the requested information.

* ☐ I understand that my participation is voluntary, and I have the right to withhold or withdraw my consent to the use of telemedicine anytime. I know that my withdrawal does not affect any future treatment with the provider.

* ☐ I understand that this telemedicine informed consent form has sole jurisdiction in the state of Florida, and therefore, I must be a resident of Florida to be treated through telemedicine. Unless the Worker's Compensation Insurance Carrier approves, any other jurisdiction.

* ☐ **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 **no disruption,** such as from children, animals, family members, other individuals, or other environmental disruptions (e.g., landscaping, traffic, telephone calls or ringtones, etc.). If such disruption occurs and is deemed by my provider to compromise the quality of the telehealth services, he/she is attempting to deliver, I understand that, at my provider's sole discretion, the session will be terminated and the full fee for the time for which the session was originally scheduled will be charged. I understand that a new fee will apply to any rescheduled appointment or future telehealth appointment.

* ☐ **RECORDING**: If my provider provides the telehealth service in the State of Florida, then 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 agree that I will not record any video or audio portion of the telehealth session. I understand that if I record any portion of the video or audio without mutual consent, **the telehealth session will be immediately terminated**, **all future treatment sessions of any kind will be canceled, and I will be discharged from MindHope of Oviedo.**

I have read and understand the terms described above. I also know that this document does not replace other agreements, documentation, or informed consent.

If you are unable to provide an original handwritten signature, you may type your name at the end of this consent form as an acceptable alternative. By doing so, you acknowledge and agree to the legal implications of the typed signature, understanding that it holds the same significance as an original handwritten signature. Additionally, you agree to email us at info@mindhopeofoviedo.com to confirm that you have typed your name on the form and attest that this is your official signature.

Patient Name (Print your name):

_____ **Date:** _____

Patient Signature