Strive Counseling Services, L.L.C
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TELEMEDICINE CONSENT

Patient Name: _____ Medical Record No: _____

1. As apart of my health care treatment I approve the use of telemedicine for any and all consultations.
2. I understand, declare and accept that telemedicine is an electronic means of communication secured by a HIPPA video compliant company, Theranest.
3. My health care provider has explained to me how the video conferencing technology will be use d to affect such a consultation 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.
4. I understand there are potential risks to this technology, including interruptions, unauthorized a ccess and technical difficulties. I understand that my health care provider or I can discontinue th e telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for schedulin g and billing purposes. Others may also be present during the consultation other than my healt h care provider and consulting health care provider in order to operate the video equipment.
6. The above mentioned people will all maintain confidentiality of the information obtained. I furt her understand that I will be informed of their presence in the consultation and thus will have t he right to request the following: (1) omit specific details of my medical history/physical examin ation that are personally sensitive to me; (2) ask non-
   medical personnel to leave the telemedicine examination room: and or (3) terminate the consul tation at any time.
7. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to p articipate in a telemedicine consultation. I understand that some parts of the exam involving ph ysical tests may be conducted by individuals at my location at the direction of the consulting hea lth care provider.
8. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude u pon the termination of the video conference connection.
9. I understand that billing will occur from both my practitioner and as a facility fee from the site fr om which I am presented.
10. I have had a direct conversation with my therapist
    during which I had the opportunity to ask questions in regard to this procedure. My questions h ave been answered and the risks, benefits and any practical alternatives have been discussed wi th me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given
  ample opportunity to ask questions and that any questions have been answered to my satisfacti
  on.

I affirm and acknowledge the information contained herein is understood and I accept the terms and conditions stated herein.

Patient's/parent/guardian signature: _____

Acknowledged on this Date:_____ Time: _____

If submitted by email send to cmullenj@strivebhm.com or by fax to 205-377-8057. If submitted by fax please confirm your fax number. _____

Witness signature: _____

Date: _____

Time:_____