Serene Minds, LLC

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Newark, DE 19713

TELEHEALTH CONSENT FORM

Patient's Name: _____ Birthdate: _____

1. I understand that purpose of this form is to obtain my consent to participate in telemedicine consult with a provider at Serene Minds, LLC for the purpose of medication management and/or psychotherapy.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment 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.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.

4. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

5. I understand the risks and benefits of a consultation, risks and benefits of other choices, and risks of not having the consultation.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

7. I understand that I may stop or take away my consent to the telehealth consultation at any time for any reason; this will not change my right to future care or treatment.

8. I understand that my medical records and medical information are private and confidential to the extent permitted by law and all existing and applicable state and federal laws regarding patient access to medical information and copies apply to this telemedicine consultation.

9. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

_____ _____

Patient/Guardian signature Date and Time