Family Therapy Center of Madison, Inc.
700 Rayovac Drive, Suite 220
Madison, WI 53711

CONSENT FOR TELEHEALTH SERVICES AND TREATMENT
(Please print, sign and return to the address above)

To our patients and families: Thank you for choosing to use telehealth care with Family Therapy Center of Madison, Inc. (FTCM). Patients and families are essential participants in health care and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, or about telehealth, please ask your provider. If you are a parent/legally-authorized representative of a child, please read this agreement with the understanding that "I" and "me" means the child.

Please note that 'telehealth' includes virtual sessions where providers and patients meet via video, through a computer, notebook, or phone. It does not usually include phone calls without video. However, because in-person contact is strongly discouraged due to the COVID-19 pandemic, patients who lack the resources to connect via video may receive some treatment via the telephone.

CONSENT FOR TELEHEALTH TREATMENT: I consent to telehealth care performed by my therapist or physician and any other associated health care providers at Family Therapy Center of Madison, Inc. (the "Providers"). This includes assessments/examinations, diagnostic testing, treatment, and other health care services deemed necessary in the Providers' professional judgment.

I understand that the practice of mental health care is not an exact science and that diagnosis and treatment carries both benefits and risks, similar to those of face-to-face sessions. One risk that is different is the risk of lack of privacy.

- I understand that FTCM is using a HIPAA compliant telehealth service and will be paying as much attention to privacy in our telehealth settings as they do for face-to-face sessions.
- I understand and will consider how to ensure privacy for myself. I will choose a time and place for my session when I will be uninterrupted and can have privacy.
- I also understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled.

PRIVACY OF TELEHEALTH SERVICES: Telehealth involves transmission of video, photographs, and/or other information. All data is sent by secure electronic means to the Providers to facilitate the treatment service being performed. I understand that:

- I will be informed of any other people who are present at the Provider's end of the telehealth encounter and that I will inform my provider of anyone else present at my end of the encounter.
- I have the right to exclude anyone from either location.
- I agree that I am responsible for providing privacy for services at my end of the encounter. All confidentiality protections required by law or regulation will apply to my care.

- I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as a phone call or an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
- If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment.
- If an emergency occurs during a telehealth encounter at a hospital or clinic, health care personnel at my location will manage the emergency.
- If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.

RECORDS AND RELEASE OF INFORMATION: Transmitted data may become part of my medical record. Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.

- I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
- The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.
- All releases of information are subject to the same laws and regulations as in-person care.

PAYMENT AGREEMENT: Billing and payment for services provided by telehealth will occur in the same manner as for face-to-face sessions, with sessions billed as telehealth. The same billing and payment policies and agreements previously in place will be followed.

- I agree to be responsible for any co-payments, deductibles, or other charges from the Providers that are not covered or paid by insurance or other third party payers – except as prohibited by any state or federal law, or any agreement between my insurance company and the Providers or Family Therapy Center of Madison, Inc.
- I authorize the Providers and Family Therapy Center of Madison, Inc. to file any claims for payment of any portion of my bills, and assign all rights and benefits payable for health care services to the provider or organization furnishing the services.
- It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Providers and Family Therapy Center of Madison, Inc.

CONSENT TO BE CONTACTED (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, Family Therapy Center of Madison, Inc., and/or other providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, or to collect any amounts I may owe, the Providers, Family Therapy Center of Madison, Inc. and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me.

- I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable.

- By providing an email address, I agree that the Providers, Family Therapy Center of Madison, Inc. and/or other Providers or staff involved with the provision of telehealth services, may contact me through that email address. I understand that email is not a secure method of communication and that using email is a potential risk to my privacy.
- I understand that neither my email address nor the email address of any Provider or Family Therapy Center of Madison, Inc. are to be used for ongoing communication.
- The email addresses are only used to schedule and facilitate the provision of telehealth services. This consent applies to all services and billing associated with my account(s) and is not a condition of receiving services.
- If I initial here, I DO NOT consent to being contacted by SMS (short message service) text message and automatically-dialed appointment reminders. ________(Initial here if you do not consent to SMS messages)

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

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Printed Patient Name Date

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Patient Signature (or Parent/ Legally Authorized Representative Signature)

Printed Name & Relationship to Patient ______________________________________

If consent for telehealth treatment is initially given verbally by telephone or video-conferencing, please list the name of the person to whom consent was given:

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Name/Title of person obtaining telephone or video-conferenced consent

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Date that verbal consent was given