**Penn Psychological Associates, L.L.C.**

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***Informed Consent for Telemedicine Services***

I understand that telemedicine 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 consent to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (my clinician) providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that all payment arrangements are the same with telehealth as with in-office visits. I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. **Payment is expected by credit or debit card.**

I understand that my therapist will make reasonable efforts to provide me with emergency resources in my geographic area. I understand that my therapist may not be able to assist me in an emergency. I understand that I may call 911 or proceed to the nearest emergency room for emergency assistance.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (my clinician) at the above contact information. If this consent has not been revoked, \_\_\_\_\_\_\_\_\_\_\_ (my clinician) may provide health care services to me via telemedicine without the need for me to sign another consent form.

*Signature of Patient (or person authorized to sign for patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*If authorized signer, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*