Healthcare Management Services

Informed Consent to Treatment for LifeSource Services

Patient Name: _____ **Patient DOB:** _____

Facility Location : _____

Services Requested: ☐ **Mental Health**

This form serves as your consent to treatment by a LifeSource clinician. Services may be delivered by one or more of the following types of licensed and qualified healthcare providers:

- Psychiatrist (MD, DO); Psychiatric Nurse Practitioner (PMHNP); Family, Geriatric or Adult Nurse Practitioner (NP); and/ or Physician Assistant
- Licensed Clinical Psychologist (PhD or PsyD); Licensed Clinical Social Worker (LCSW)

By signing this consent, you confirm:

- I have been informed of my rights, including the right to consent to or refuse treatment; I have received or been offered a copy of LifeSource's Notice of Privacy Practices, Client Rights' and Grievance policies, which provide information about how LifeSource uses and discloses Protected Health Information.
- I authorize any entity with medical information about me to release said information to my insurance company or to the Centers for Medicare and Medicaid Services and its agents, if needed, to determine the benefits payable for requested services.
- I request that payment of authorized insurance benefits be made on my behalf to the LifeSource clinician designee for requested services. I understand that my insurance company may assign a portion of the bill as patient liability. I understand that my financially responsible party may be informed that I am receiving services for billing purposes unless I request otherwise.
- I authorize the release of information to my Attending Physician and/or facility for the purpose of coordination of care. I understand that my medical records will be kept on file at the site where requested services are provided, and that the release/ disclosure of my protected health information is subject to all HIPAA guidelines. The duration of this consent is until the discontinuation of service by the provider or patient.

Telemedicine Information

This health care provider may engage you in the delivery of one or more of the requested services via telemedicine. You have the option to decline telehealth services and instead seek face to face services.

Telemedicine is the use of electronic communication technologies by health care providers to deliver services to individuals located at a different site than the provider. There are potential risks to this technology, including interruptions, technical difficulties, and much more rarely, unauthorized access. Certain conditions cannot be diagnosed or treated via telemedicine, and the healthcare provider(s) will determine whether or not the condition being diagnosed and/ or treated is appropriate for a telemedicine encounter; if it is not, the provider will communicate this and explain alternative options.

In any telemedicine visit, you will have a direct conversation with the health care provider and have the opportunity to ask any questions in regard to telemedicine services. Questions shall be answered, and the risks, benefits and any practical alternatives discussed in a language you understand.

Others may also be present during the consultation other than the health care provider in order to set up or operate the video equipment, but all will maintain confidentiality of the information obtained. Because you

are located in a setting outside of this provider's physical office, processes such as electronic appointment scheduling, electronic prescription orders/ refills and patient education delivered electronically may occur.

All existing laws regarding access to medical information and copies of medical records apply to telemedicine services. *Please note that telecommunications are not recorded or stored*. Reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telemedicine technologies, and all existing confidentiality protections under federal and state law apply to information disclosed during telemedicine sessions.

By signing this consent, you certify, when and if telehealth services are used for care delivery:

1. LifeSource has given me information explaining how the video conferencing technology will be used and that the delivery of services may not be the same as a direct patient/ health care provider visit due to the fact that I may not be in the same room as my health care provider.
2. I understand that my health care provider or I may discontinue the telemedicine session if it is felt that the videoconferencing connections are not adequate for the situation.
3. I further understand that I will be informed of any other person(s) presence in the consultation and have the right to request any of the following:
    i. (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine room: and or (3) terminate the consultation at any time.
4. I have had the alternatives to telemedicine explained to me, and in choosing to participate in telemedicine services, I understand that some parts of the exam involving physical tests must be conducted by individuals at my location at direction of the consulting health care provider.
    i. If I am located in a personal setting, such as my home, these tests may be arranged through the use of local doctor's offices, clinics, etc and will be discussed and agreed to with my health care provider prior to scheduling.
5. In an emergent situation, I understand that the responsibility of the telemedicine clinician is to advise my local practitioner, and that the clinician's responsibility will conclude upon the termination of the video conferencing connection.
6. I may withhold or withdraw consent to the telemedicine services at any time, without affecting my right to future care of treatment.

I have read this form, or had this form explained to me. I fully understand its contents including the risks and benefits of services. I have been given ample opportunity to ask questions and that any questions were answered to my satisfaction.

REQUIRED SIGNATURES: ***(If signing as Legal Guardian, proof of guardianship required)***

_____	_____	_____
Patient or Legal Guardian Signature	Patient or Legal Guardian Printed Name	Date
_____	_____	_____
Witness Signature *(If signature illegible)*	Witness Printed Name	Date

Or, in accordance with Medical Statutes:

_____	_____	_____
Responsible Party Signature	Responsible Party Printed Name	Date

Relationship to Patient (required): _____