CONSENT for Oneida County Public Health- Reproductive Health Clinic (RHC) TELEHEALTH visits:

RHC Client **Name:** _________________________________ [Pt. / Client #________________________]
(PRINT NAME ABOVE) [RHC Office staff will fill in client number above]

1.) I authorize Oneida County Public Health Department's (OCHD) - Reproductive Health Clinic (RHC) to allow me to participate in telehealth services now or in the future.
2.) ***I understand that all Family Planning Reproductive Health services are confidential and voluntary***.
3.) I understand that this service is not the same as a direct patient/provider office visit because I will not be in the same room as the provider providing the service. I understand that parts of my care and treatment which require physical tests or examination may be conducted by other local health care providers at a different location but under the direction of the telemedicine health care provider.
4.) My provider has fully explained to me the nature and purpose of the audio and/or videoconferencing technology and has also informed me of expected risks that may arise during the telehealth session, benefits and complications (from known and unknown causes), as well as possible alternatives to the proposed session. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5.) I am aware that either my provider or I can discontinue the telemedicine visit if we believe that the telehealth conferencing connections are not adequate for the situation.
6.) **I understand that *the telehealth session will not be audio or video recorded at any time*.**
7.) I agree to permit my patient health information (PHI), to be shared with other individuals for the purpose of scheduling and billing.
8.) I know I have the right to request the following:
    a. Omission of specific details of my medical examination that are personally sensitive, or
    b. Asking non-medical personnel to leave the telemedicine room at any time , or
    c. Termination of service at any time.
9.) I understand that my insurance, (third party*) will be billed by both the local health care provider and the telemedicine health care provider for telehealth services.
10.) My consent to participate in this telehealth service shall remain in effect until I revoke my consent in writing. I understand that each time in the future that I appear for a telehealth visit, I am consenting to such visit.
11.) I have read this document carefully, and understand the risks and benefits of telehealth appointments and *I agree that there have been no guarantees or assurances made about the results of this service.*
12.) I hereby consent to participate in telehealth appointments with the OCHD-Reproductive Health staff.

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Signature of Patient/Client Date

An EXPLANATION OF TELEHEALTH was provided to client by: ☐ access to RHC website or, ☐ in-person visit.

I hereby certify that I have explained the nature, benefits, risks of, and alternatives to the telehealth procedure. I have offered to answer any questions and have fully answered all such questions.

____ ___________________________

OCHD-RHC Provider's Signature Date

* *Third party billing will be done in a manner that does not breach client confidentiality, particularly in sensitive cases (such as; adolescents or young adults seeking confidential services, or individuals for whom billing the policyholder could result in interpersonal violence).*