# Frontier Health and Wellness
# Informed Consent for Telehealth Services

on behalf of its contracted providers

| PATIENT NAME: _____ LEGAL GUARDIAN NAME: _____ (IF APPLICABLE) | PATIENT'S DATE OF BIRTH _____/_____/_____ | TODAYS DATE: _____/_____/_____ |
|---|---|---|

PROVIDER NAME(Please Circle): Dr. Hjellen V. Hutton, LPC K. Moore, NP T. DeMure, NP

LOCATION: 4241 B ST. SUITE 305, ANCHORAGE, AK 99508

**Introduction:**

Telehealth involves the use of electronic communications to enable your provider to meet with you at a separate location to continue ongoing medical/clinical care. The information discussed may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. The telehealth platform used by FHW and its contracted providers is HIPAA Compliant and the protection of your personal health information is our utmost priority.

**Expected Benefits:**

- Alternate access to medical care by allowing a patient to remain within his/her home (or at a remote site) while still being able to meet directly with their provider.
- Increased access to medical/clinical evaluations and management during times of restricted mobility.
- The ability to maintain and adhere to the state mandated social distancing during the COVID-19 pandemic.

**Possible Risks:**

As with any medical/clinical treatment, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician and additional face-to-face visits may be required to effectively manage patient care.
- Delays in medical/clinical evaluation and treatment could occur due to deficiencies or failures of the electronic equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. FHW or its contracted providers will not record telehealth sessions to provide additional safeguards against any such privacy breach.
    - FHW or its contracted providers will not be able to mange the privacy and security of your environment while participating in a telehealth appointment and request that you take all necessary precautions to protect your personal health information by securing your surroundings prior to your appointment.
- In rare cases, a lack of face-to-face treatment may result in judgment errors due to lack of environmental controls.

**By signing this form, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information.
4. I understand that in person medical/clinical care may be available to me, and that I may choose to see the doctor face to face in lieu of telehealth. I will, however, follow all Federal, CDC, State of Alaska and Municipality of Anchorage guidelines and mandates in regards to the containment of the COVID-19 Virus.
    a. I understand that FHW and its contracted providers reserve the right to refuse face-to-face services if myself or anyone I have been in close contact with has been/is currently ill or is experiencing symptoms of the COVID-19 virus.
    b. I understand that in the event that any member of the FHW staff or its contracted providers is ill or experiencing symptoms of the COVID-19 virus my regularly scheduled face-to face appointment may be moved to a telehealth appointment to maintain the health and safety of all patients.
5. I understand that I may still be expected to pick-up a hard copy of my medication prescription if the medication I am being prescribed is mandated by the DEA to be delivered direct to the pharmacy.

**Patient Consent To The Use of Telehealth**

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

*I hereby authorize Frontier Health and Wellness and its contracted providers to use telehealth in the course of my diagnosis and treatment.*

*Signature of patient or legal guardian* _____ *Date:* _____

*If Authorized signer, relationship to patient:* _____

I have been offered a copy of this consent form (initial) _____