10801 Hickory Ridge Rd Ste. 210
Columbia, MD 21044
410-992-3796
410-992-3973

Solutions for Mindfulness

Fax

To: **From:**

Fax: **Pages:**

Phone: **Date:**

Re: Consent form **cc:** Dr. Onwuanibe

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

SFM
Solutions for Mindfulness, P.A.

10801 Hickory Ridge Road
Suite 210
Columbia, Maryland 21044
Phone 410-992-3796
Fax 410-992-3973
www.solutionsformindfulness.com

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. Patients are responsible for any out of pocket expenses that are not covered by your insurance, which may include deductibles, co-payments, co-insurance, and non-covered services.
6. In the event coverage terminates or services are not covered, I acknowledge that I am responsible for all charges incurred based on contract provisions until its termination date.

CONSENT TO USE THE TELEHEALTH BY SECUREVIDEO

Telehealth by SecureVideo is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

Patient Name (Print)

_____ _____

Patient Signature Date