PATIENT NAME: _____

EMAIL: _____

Virtual Health consent to treat

Please initial on the lines and sign at the bottom

_____In home tele-health is completely voluntary and patients can end treatment at any time without losing the ability to receive treatment at Orion Behavioral health.

_____Sessions will not be recorded by this clinic. It is expressly forbidden that the patient or family record or video the session.

_____HIPPA compliance will be maintained throughout the sessions. Security measures including encryption will be employed but security cannot be absolutely guaranteed. Limitations of confidentiality Suspicion of child abuse, neglect or threats to hurt self or others.

_____Back-up plan if connection fails, is that the patient calls the office (907)696-7466 and session will be finished via phone

_____Billing policy: patient will be billed the same as an in person evaluation. There will be a charge for facility fee and facilitation of telemedicine.

_____Web cam should be in a semi-public area of the house and there needs to be an appropriate adult present throughout the session. The clinician will be apprised of all people in the room. Sessions will only be held in the patient's house and not via portable devices unless explicitly authorized by clinician.

_____Liability waiver: OBHN or the provider will not be held liable for any technological difficulties that may arise on the computer or any physical damage to this equipment during the sessions. The patient and/or family are responsible for purchasing and maintain any equipment in their home. The patient and/or family are responsible for furnishing an adequate internet connection to allow the video conference.

_____ _____

Guardian/ Patient Signature **Date**