Babson College Health Services

Consent to Participate in Telehealth Treatment

Last Name: _____ First Name: _____

Birthdate: _____

Introduction:

Prior to your telehealth visit, please read the information below and consent for telehealth treatment. Telehealth involves the use of electronic communications to enable health care providers at a different location from the patient to share individual patient medical information for the purpose of providing patient care. If a telehealth visit does not work for you for any reason, please let us know and alternative support options can be considered. In addition, phone support is available to you by calling the Student Health Services department at 781-239-6363.

Health care providers may include physicians, nurse practitioners, registered nurses, dieticians and other subspecialists. The information provided or obtained 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

Benefits/Possible Risks:

1. I understand that my health care provider wishes me to engage in a telehealth consultation using Webex. I understand that there may be the need for an abbreviated in person visit for further assessment and diagnostic testing if warranted. The benefits of telehealth may include removing transportation and travel barriers, minimizing time constraints and providing greater opportunity to prepare in advance for treatment sessions.

2. My health care provider has explained to me how the video conferencing technology will be used to effect a consultation and that telehealth may not be the same or as complete or effective as face-to-face services. In addition, I understand if I or my healthcare provider believes I would be better served by face-to-face service, I may be referred to a provider in my area to receive this service. Finally, there are potential risks associated with any form of mental health treatment, and despite my efforts and the efforts of my provider, my condition may not improve and, in some cases, may become worse.

3. I understand that my health information may be shared with other health care providers for medical consultation and appointment scheduling purposes.

4. I understand there are potential risks associated with telehealth. These may include, but are not limited to, the possibility that transmission of my medical information could be disrupted or distorted by technical failures or interrupted by unauthorized persons, and/or misunderstandings between the healthcare provider and me. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the Webex videoconferencing connections are not adequate for the situation.

5. If other health care providers are present during my visit or able to see or hear my visit, I will be informed in advance of my treatment of their presence and, in addition to my other rights, will have the right to any or all of the following (1) refuse to permit their attendance; (2) omit specific details of my medical history/physical examination that are personally sensitive to me; and/or (3) terminate the consultation/visit at any time. If I so consent to their attendance, all other health care providers present during my treatment will be bound by obligations of confidentiality of the information obtained or provided during the session. Similarly, I agree to conduct my visit in a private space without any other attendees present, or able to see or hear my visit unless my healthcare provider and I have specifically agreed that I may have other attendees present. If someone comes into the room during my visit, I will pause my video and restart only after such person has left the room. I understand that the session will not be recorded by the healthcare provider, and that I will not record the session.

6. I have had the alternatives to a telehealth consultation explained to me by my healthcare provider, and am choosing to participate in a Webex telehealth consultation. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

7. The laws that protect the confidentiality of my medical information also apply to telehealth. The information disclosed by me during my course of treatment is confidential except where applicable law provides otherwise. For example, exceptions to confidentiality laws include the requirements to protect me or the public from serious harm and/or to respond to a court order. Similarly, all existing laws regarding access to my medical information and copies of my medical records also apply.

By signing this form, I certify:

* I have read and understand the information provided above regarding telehealth, have discussed it with my health care provider, and all of my questions have been answered to my satisfaction..

* That I fully understand its contents including the risks and benefits of the procedure(s).

* 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 others without my consent.

* 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.

* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

***** I hereby authorize Babson College Health Services to use telehealth in the course of my diagnosis and treatment for any visits during my enrollment as a full time eligible student.

By signing below, I acknowledge that I have reviewed this document and give my consent:

Signature of Patient (or parent/guardian if patient is under the age of 18):

_____

Date: _____

If parent/guardian, relationship to patient: _____

Date: _____