∮ INTEGRAL HEALTH ASSOCIATES

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TELEHEALTH CONSENT FORM

This consent and acknowledgment form covers the use of telehealth by Integral Health Associates.

Within this document, "telehealth" includes communication forms such as telephone, cellular phone, and audio-video that occur over information networks rather than in person face-to-face. "Integral Health Associates" (herein referred to as "IHA") includes the business entity known as such in the State of Connecticut and clinical providers contracted by the entity.

By signing this form, I am indicating that I understand and am in agreement with the following:

1. Engagement in telehealth by myself and IHA is completely voluntary. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. IHA has the right to offer or cease the offering of telehealth for any reason not specifically excluded by law.

2. IHA will not disseminate any personally identifiable information obtained through the use of telehealth to other entities without my consent.

3. Medical documentation of telehealth sessions by IHA will occur based on generally accepted standards, but Integral Health Associates will not voluntarily record or allow recordings of any part of any telehealth session. Likewise, I agree not to make or allow recordings of any part of any telehealth session.

4. Despite reasonable efforts by IHA, there are risks and possible consequences from telehealth including, but not limited to, possible disruption of the transmission of my health information by technical failures, possible access and misuse of my health information by unauthorized persons, and the possibility that telehealth services may not be as complete or effective as face-to-face services.

5. Services provided by IHA through telehealth services are professional services that may or may not be covered by insurance companies. IHA may be able to assist you with filing insurance claims, but ultimately, I am responsible for full payment just as I would be for face-to-face office visits.

6. I agree to be available for telehealth sessions at the time of my appointments. This includes having the ringer on for telephone appointments, logging in for video appointments, and being in a quiet, private location with reliable telephone, cellular, wifi, or ethernet connectivity as needed.

7. Missed appointments will be charged the same as missed face-to-face sessions according to office policy. If I am available and my provider does not contact me within 15 minutes of a scheduled telehealth session, I am free to move on to other activity without being charged for a missed appointment.

8. If a telehealth session is interrupted due to a technical problem, I agree to immediately make reasonable attempts to reconnect or contact my provider through some other means if available.

I hereby acknowledge my understanding of the above items, indicate my agreement to them, and consent to the use of telehealth as part of my overall treatment provided by Integral Health Associates.

Patient Name (Print): ________________________________ Date of Birth: __________________

Signature of Patient (Parent or Guardian if Patient is under 18 years old):________________________

Name of Parent or Guardian if Patient is under 18 years old (Print):______________________________

Date Signed: ________________