ART OF RECOVERY SERVICES NFP
1512 ARTAIUS PARKWAY, STE 200, LIBERTYVILLE, IL 60048

Client Name: _____

DOB: _____

Client ID: _____

TELEMEDICINE INFORMED CONSENT FORM

1. I understand that my health care provider recommends engaging in Telehealth services with me to provide treatment and that there are many benefits to Telehealth, including easier access to care.
2. My health care provider has explained to me how the video conferencing technology will be used and that my telehealth visit will be similar to a direct patient/health care provider visit, except for the fact that I will not be in the same room as my health care provider.
3. 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 telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that it is my responsibility to notify provider of any other persons at my location and that it is my responsibility to ensure privacy of my location (including disconnecting virtual assistant devises such as Alexa, Siri, Echo etc.)
5. I have had the alternatives explained to me, and I am choosing to participate in a Telehealth visit.
6. **I UNDERSTAND THAT TELEHEALTH IS NOT AN EMERGENCY SERVICE. IN THE EVENT OF EMERGENCY, I WILL USE THE PHONE TO CALL 9-1-1 AND/OR APPROPRIATE EMERGENCY CONTACT**
7. I understand that Telehealth visits are using the same Fee Schedule as regular in-person visits.
8. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to Telehealth. 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.
9. I understand that I can file a formal grievance in order to resolve any potential ethical concerns or issues that might come up as a result of Telehealth.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of Telehealth visit
- To maintain confidentiality, I will not share my Telehealth appointment link or information with anyone
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Was Verbal Consent obtained for this document by the client and/or guardian? Yes No

_____ _____

Client's/Parent/Guardian signature Date

_____ _____

Witness/AOR signature Date