Brazos Valley Rehabilitation Center
1318 Memorial Drive
Bryan TX 77802
979-776-2872
https://brazostherapy.org

CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

Consent for Treatment. I voluntarily request Brazos Valley Rehabilitation Center ("BVRC") and such clinicians and other health care providers as they may deem necessary ("BVRC Telehealth Providers") to participate in my medical care through the use of telemedicine. I understand that BVRC Telehealth Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that BVRC Telehealth Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure. If BVRC Telehealth Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to BVRC Telehealth Providers. I understand and agree that the information I am authorizing to be released may include: 1) test results, diagnosis, treatment, and related information; 2) information received by BVRC Telehealth Providers from my medical team and insurance plan. I understand that the disclosure of my medical information to BVRC Telehealth Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering. I acknowledge that:

- Transmitted Data may become part of my medical record.
- Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.
- I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
- The BVRC Telehealth Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.

United Way of the Brazos Valley

BRAZOS VALLEY
REHABILITATION CENTER

Brazos Valley Rehabilitation Center
1318 Memorial Drive
Bryan TX 77802
979-776-2872
https://brazostherapy.org

- All releases of information are subject to the same laws and regulations as in-person care.

I authorize the following person(s) to be present in and facilitate my/my child's telehealth session and access medical records (please include relationship to patient):

_____

Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the BVRC Telehealth Providers that are not covered or paid by insurance or other third party payers – except as prohibited by any state or federal law, or any agreement between my insurance company and the Providers. I authorize the BVRC Telehealth Providers and BVRC to file any claims for payment of any portion of the patient bills, and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the BVRC Telehealth Providers, and/or other providers involved with the provision of telehealth services.

Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the BVRC Telehealth Providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the BVRC Telehealth Providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact and service delivery may include SMS text messages, phone calls, video conferencing platforms and I agree to be responsible for any data and wireless charges that may result.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____

PRINTED PATIENT NAME PATIENT OR PARENT/ LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE

_____

PRINTED NAME & RELATIONSHIP TO PATIENT DATE

_____

NAME & TITLE OF PERSON OBTAINING TELEPHONE OR VIDEO-CONFERENCE CONSENT DATE/ TIME

United Way
United Way of the Brazos Valley