ADVANCED BEHAVIORAL MEDICINE, PC

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

Patient name:_____,

I hereby consent to engaging in telemedicine at Advanced Behavioral Medicine, as part of my/their medical treatment and psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psycheducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have secure internet connection or a smart phone device with a strong connection at a location deemed appropriate for services.

Financial Obligation: Fees associated with telemedicine appointments are billable to most major insurance companies and Advanced Behavioral Medicine with bill my insurance on my behalf. Any fees associated with my telemedicine services not covered by my insurance remain my responsibility. I agree to have my credit/debit card information in file at Advanced Behavioral Medicine. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, Advanced Behavioral Medicine will cancel my appointment and I will be charged in accordance with the cancelation policy.

Clients with insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I authorize insurance benefits to be paid directly to Advanced Behavioral Medicine and for the release of any information to my insurance provider required for processing my claims.

Self-pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Advanced Behavioral Medicine cancellation policy as documented by my signature on the informed consent

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Advanced Behavioral Medicine and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services

Parent/Guardian name:_____ Parent/Guardian signature_____

Relationship to patient_____ Date: _____

If 14 years or older Patient Signature_____ Date: _____