MANDALA
FAMILY WELLNESS

Telehealth Informed Consent

As a patient receiving mental health services through telehealth methods, I understand that such service is provided by technology (Including but not limited to video, phone, text, and email) and does not Involve direct, face to face communication.

If a remote video platform Is utilized, then I understand that I will need an installed and working webcam and speakers or headphones. I understand that I will receive an e-email with a link to open the remote video program and if not previously downloaded, there may be some time necessary to download the program onto my computer before it starts. I understand I will need a PC or Mac or tablet; a Chromebook or iPhone or another cellular phone or other Internet enabled device may not work and may not be appropriate.

The quality of the communication depends upon the sophistication and reliability of the telehealth medium used based upon my own Internet connection, my provider's Internet connection, the program itself, or the program's Internet cloud-based system. I understand that there could be some miscommunication or lack of communication as a result of technological limitations or unreliability inherent within my or my provider's Internet service and platform utilized which are not under the control of myself or my provider.

I understand that other Mandala Family Wellness staff be may present during the session to initiate the connection or if there is a problem only to assure reliable operation of the telehealth system. Such staff will maintain confidentiality of any information under contractual arrangements and/or Federal law and/or State law.

While telehealth services allow for greater convenience in service delivery, there are risks In transmitting Information over the Internet that Include, but are not limited to: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties which may not be under the control of either my mental health services provider or myself.

In the event of disruption of the telehealth service or in the event of an emergency, or for other routine or administrative reasons, it may be necessary to communicate by other means such as direct telephone communication. The following phone numbers will be set up as a backup in the event the telehealth platform cannot be utilized from the start of the scheduled session or at any time after the session begins:

Provider: _____

Patient: _____

It Is my responsibility to maintain privacy and a controlled quiet environment on my end of the telehealth communication which means that there should be not any disruption such as from children, animals, family members, other Individuals, or other environmental disruptions (e.g., landscaping, traffic, telephone calls or ringtones, etc.). In the event that such disruption occurs and is deemed by my provider to compromise the quality of the telehealth services he/she is attempting to deliver, I understand that, at my provider's sole discretion, the session will be terminated and the full fee owed for the period of time for which the session may have originally been scheduled will be charged. I

understand that a new fee will be obligated to be paid by myself for any rescheduled or future telehealth appointment.

I understand that unless otherwise notified by Mandala Family Wellness staff, telehealth services may be a covered benefit under my Insurance plan and co-pays and deductible will apply. The same No-Show and cancellation policies previously signed and agreed to at the start of treatment remain in effect.

I understand that the documentation my provider writes in relation to any telehealth session will be created and stored in the same EHR system as any note created from a face-to-face appointment/session. Such documentation falls under the same legal, professional, and contractual guidelines as any document stored as the result of a face-to-face appointment/session. No different than any documentation in my record, I understand that I have access to information resulting from the telehealth service to the extent required by State and Federal law.

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 so long as it is provided in writing in accordance with State and/or Federal law without affecting my right to future care or treatment. As long as this consent is in force, telehealth services may be provided to me without the need to sign another consent form.

I understand that telehealth services provided to me must comply with State and Federal (HIPAA) law and I acknowledge that I am aware of such laws. I understand that the reporting requirements (e.g., to law enforcement or a state agency) which may be mandatory under State law are no different than If the service was provided face-to-face as per the Consent Form I originally signed for service.

If my provider provides the telehealth service In the State of Florida, then according to Florida law and under penalty of Florida law, I understand that there will be NO recording of any video or audio information from the telehealth session by myself or my provider or any other participant in my telehealth session(s) without the mutual signed consent of myself and my provider (and any other participant as applicable).

I understand that if I do record any portion of the video or audio Information without mutual consent, the telehealth session will Immediately be terminated, all future treatment sessions of any kind will be canceled/terminated, and I will be discharged from my provider and all Mandala Family Wellness providers.

- I have read or had this form read and/or had this form explained to me.
- I have been given ample opportunity to ask questions and my questions have been answered.
- The risks, benefits and any practical alternatives have been discussed in language I understand.
- The alternatives to telehealth consultation have been explained to me, and I am choosing voluntarily to participate in a telehealth consultation.

This document does not replace other agreements, contracts, or documentation of Informed consent.

Patient Name Patient or Legal Guardian (If applicable): _____

Signature of Patient, Parent or Legal Guardian (Date): _____