1200 Reedsdale Street
Pittsburgh, PA 15233-2109
www.pittsburghmercy.org
1-877-637-2924

Informed Consent for Telehealth Services

I, ____, agree to participate in Televideo Services via interactive video conferencing with the provider(s) on my treatment plan.

I understand that the following may occur:

1. Discussion of my medical history examinations and tests
2. Discussion and assessment of psychiatric symptoms and behaviors
3. Development and maintenance of treatment / service plan
4. Therapeutic counseling and behavioral services
5. Admission and discharge planning

I understand my participating is voluntary and I may withhold or withdraw consent to the use of Televideo at any time without affecting my access to other available services. If I withhold or withdraw my consent, I may experience a delay in diagnosis or treatment until a psychiatrist or clinician is available or arrangements for a transfer can be made.

I understand that, at this time, there are some risks involved in receiving my care in this manner. All reasonable and appropriate measures will be made to eliminate all confidentiality risks. I understand that my session will be private unless I request that someone remain in the room with me.

I understand that interactive video services via Zoom is the method of televideo delivery used by Pittsburgh Mercy Health System which is HIPAA Compliant. I have been informed of the name of the provider(s) and the role of the provider(s) in my ongoing care.

If I am using the televideo service via a kiosk at a Pittsburgh Mercy facility, I will be shown the equipment and a demonstration of the equipment will be provided prior to receipt of this service. I have been informed that a staff member will be available to assist me if needed.

My provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read this consent form.

I give my consent to receive services through interactive video conferencing. I understand the services I receive are part of my medical record. I understand the provider will have access to my relevant medical information, including psychiatric and/or psychological information, alcohol and/or drug use, and mental health records. I understand this consent form will become part of my medical record.

I am giving consent for the following person(s) to be in the room with me during my Televideo session.

Print Name of Person(s) in room with Patient ____

Print Patient Name____

____ ________________________

Signature of Person Served OR Signature of Guardian/Responsible Person* Date/Time
**if under 14 years of age and primary diagnosis is MH*

____ ________________________

Witness Signature Date/Time

Consumer Name: ______________________________

Medical Record # ______________________________