HEALTH PROMOTION
DISEASE PREVENTION
FORT PECK TRIBES

Informed Consent for Telemedicine Services

Definition of Telehealth

Telehealth involves the use of electronic communications to enable the Fort Peck Tribes Health Promotion Disease Prevention (HPDP) Program to connect with individuals and their families using interactive video and audio communications.

Telehealth includes the practice of clinical health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of clinical data. Clinical professionals include, but are not limited to, those who are Licensed Independent Practitioners (LIP).

Telemedicine Clinical Services: The HPDP School Based Health Centers (SBHC) or additional HPDP programs, must have a signed consent from a parent or legal guardian before providing services to youth, except where federal and/or state laws allow youth to access such treatment without parent/guardian consent.

I hereby request and authorize treatment for any and all health care services available from and deemed necessary by the providers and volunteers of the HPDP School Based Health Clinics. These services may include, but are not limited to, wellness care, evaluation, treatment of acute illness and injuries, immunizations, blood studies, dental screening and treatment, wellness counseling and mental health evaluations and counseling. Consent is also given for referral of care and, if needed, emergency transportation, to other physicians, health care professionals, hospitals, clinics or health care agencies as deemed necessary by the SBHC staff. Consent for service is authorized for any SBHC run by HPDP to provide services until your child reaches the age of 18 years old. I may choose to limit or withdraw the consent for any or all services by notifying HPDP in writing.

I understand that I will be consulted and notified by phone or in person prior to any immunizations, laboratory /radiology tests or dispensation of medications, unless the condition is life threatening.

CONFIDENTIAL CARE: I am aware that the information about my child is confidential and will not be shared with others, including school personnel, except in the following circumstances: 1. Permission to share information is given by a signed release of information. 2. The student shows risk of suicidal behavior. 3. The student plans to do serious bodily harm to another person. 4. The student has a life-threatening problem and is under 18 years old. 5. There is a reason to suspect abuse or neglect. 6. Certain communicable diseases must be reported to the State Health Department. A student's consent is legally required to release information about the following kinds of diagnoses and treatment: pregnancy, sexually transmitted disease, alcohol and drug use or mental health counseling. The SBHC encourages youth to involve parents/guardians in health care decisions whenever possible.

ASSIGNMENT OF INSURANCE BENEFITS; I authorize HPDP to request on my behalf, and to collect directly, all public and private insurance coverage benefits (including Medicare, if applicable) due for products and services supplied by HPDP providers in the SBHC. In the event insurance benefits are paid directly to me, I will endorse to HPDP all checks for such payments.

MEDICARE CERTIFICATION (when applicable): I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct.

RELEASE OF HEALTH INFORMATION TO PAYERS: I authorize HPDP to disclose any health information to my insurers (including the Center for Medicare & Medicaid Services or its representatives, if applicable) necessary to facilitate the processing of claims or audit of payments relative to the services provided to me or my child by HPDP.

By signing below, I am acknowledging full understand of the above notice and hereby indemnify and hold harmless the providers, medical office and other persons who act in reliance upon this authorization.

Parent/Guardian Signature: _____ Relationship _____ Date _____

HIPAA/NOTICE OF PRIVACY PRACTICES: We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the HPDP Privacy Officer. The Fort Peck Tribes Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. The Fort Peck Tribes Notice of Privacy Practices is posted on our website at http://www.fortpecktribes.org/hpdp/staff.html and is posted in each SBHC.

By my signature below I also acknowledge I have been offered a copy of the Fort Peck Tribes Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date _____

Patient Rights

I understand that I have the rights with respect to telehealth:

1. HPDP utilizes platforms that are secure, encrypted audio/video transmission software to deliver telehealth. Our practice is in compliance with the HIPAA Security and Privacy rules to ensure that appropriate safeguards are in place to prevent a confidentiality breach with your health information. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the Fort Peck Tribes Health Promotion Disease Prevention (HPDP) program, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.
2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are mandatory reporting, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim.
3. 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, without affecting my right to future care or treatment.
4. I understand that if the clinical professional believes I would be better served by another form of intervention (e.g., face-to face services), I will be referred to my primary health care provider or other clinical facility, and that despite my efforts and the efforts of the clinical professional, my condition may not improve, and in some cases may even worsen.
5. I understand that my healthcare information may be shared under the HIPAA need to know rule for the purposes of scheduling and billing. Clinical staff may also be present during the consultation in order to operate the telemedicine cart or assist with the visit. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my clinical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the telehealth room, and/or (3) terminate the consultation at any time.
6. I understand that I have a right to access my clinical information and copies of my clinical records in accordance with the laws pertaining to the state in which I reside.
7. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer based clinical services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
8. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
9. I understand the alternatives to clinical care through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology or other alternatives that support the Telehealth service.

Patient Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with the clinical professional, and all my questions have been answered to my satisfaction.
I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By signing, I acknowledge that I have read and understand the Consent for Treatment for Telehealth Services, and that a copy of the Consent for Treatment for Telehealth Services available upon request.

Student Name _____ DOB _____

Printed Name _____ Relationship to student _____
(Parent/Guardian)

Signature _____ Date _____
(Parent/Guardian)

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____

Additional Contact Information

Name: _____ Phone Number: _____