**ROGER LUDWIG, M.A., P.C.**

2315 Dunn Avenue ● Cheyenne, WY 82001

Office: (307) 637-5004 ● Cell: (307) 630-4829 ● Fax: (307) 637-5011

**Telehealth Consent Form**

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when they are located at a different site than the provider; and hereby consent to Roger Ludwig providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. The program used by this therapist is Thera-LINK and HIPPA compliant. Sessions are completed on the therapist’s side in the privacy of my office.

By signing below, you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that my healthcare information may be shared with other individuals for billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained.
4. I understand there are potential risks with this technology: The video connection may not work or that it may stop working during sessions.
5. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

**Patient Consent to the Use of Telehealth**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with telehealth and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose with the use of telehealth. This consent is valid for 12 months for telehealth services with the health care provider.

Client/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_