256 Honeysuckle Rd, Ste 12
Dothan, AL 36305
Phone: (334) 792-6736
Fax: (334) 792-6737
www.WireBG.com

Leona Graham, MD
William Elkington, MD
Ruthanne Wilkes, MSN, FNP, PMHNP
Dallarie Jamison, MSN, FNP, PMHNP
Alexia Powell, MSN, FNP, PMHNP

Terry Bradley, MS, LPC
Penelope McDonald, MS, LPC
Fran Espey, MS, LPC
Walter Williams, MS, ALC
Stephanie Epding, MS, ALC

Telehealth Consent Form

I ___________________________________ agree to receive this health care service, Psychiatry, Medication Management or Counseling, as a telemedicine service. I understand that the health care practitioner is located at Wiregrass Behavioral Group 256 Honeysuckle Road, Suite 12, Dothan, Alabama 36305.

A telemedicine service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for initial and follow-up telemedicine services with the health care provider, medical treatment, provider payment, and health care operations. The original document is retained in the medical record, and the recipient receives a copy.

I also understand that:

- **I acknowledge that it is my responsibility to determine my insurance benefits for telehealth/telemedicine coverage**. Although my insurance covers in person visits, my benefits may differ and may not cover telehealth/telemedicine visits. **If my insurance does not cover telehealth/telehealth visits, I will be responsible for the balance.**
- I can decline the telemedicine service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
- If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:

• The same confidentiality protections that apply to my other medical care also apply to the telemedicine service.
• I will have access to all medical information resulting from the telemedicine service as provided by law.
• The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
• I will be informed of all people who will be present at all sites during my telemedicine service.
• I may exclude anyone from any site during my telehealth service.
• I may see an appropriately trained staff person or employee in-person immediately after the telemedicine service if an urgent need arises **OR** I will be told ahead of time that this is not available.
• I may contact the healthcare provider at phone number for any questions I have related to medical services received through a telemedicine provider/site.
I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Recipient___________________________________ Date________________________

Signature of Parent or Legal Representative _____________________________Date______________