TELEMEDICINE INFORMED CONSENT

LORIE BIALOBRESKI LICENSED CLINICAL SOCIAL WORKER PROFESSIONAL CORPORATION

Patient Name: ____________________________________ DOB______________________________

1. I understand that Lorie Bialobreski, LCSW wishes me to engage in a telemedicine consultation.

2.LorieBialobreski,LCSW has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/behavioral health care provider visit due to the fact that I will not be in the same room as my behavioral health care provider.

3.I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that Lorie Bialobreski, LCSW, or I can discontinue the telemedicineconsult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4.In an emergent consultation, I understand that the responsibility of Lorie Bialobreski, LCSW is to direct me to the nearest ER, direct me to call 911, or contact 911 on my behalf, and that Lorie Bialobreski's responsibility will conclude upon the termination of the video conference connection.

5.I have had a direct conversation with Lorie Bialobreski, LCSW, during which I had the opportunity to ask questions in regard to this procedure.

6.My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature __________________________________Date______________________________