**MBH WELLNESS CLINIC**

**TELEMEDICINE RECIPIENT CONSENT FORM**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to receive counseling services as a telemedicine service. I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to all forms of communication including phone, text messages, or email. I understand that the health care practitioner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ located in another location at MBH Wellness Clinic 100 Century Park S, Suite 102 Birmingham, AL 35226 or 401 4th Ave S Jasper, AL 35501. A telemedicine service means that my visit with my practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for twelve months for follow-up telemedicine services with the mental health care provider, medical treatment, provider payment, and health care operations. The original document is retained in the medical record.

I also understand that:

* I can decline telemedicine service at any time without affecting any 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 mental health practitioner in-person if I decline telemedicine services.
* The same confidentiality protections that apply to my other mental health care also apply to the telemedicine service.
* I will have access to all medical information resulting from the telemedicine service as provided by law.
* 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 telemedicine service.
* I may contact the mental health care provider at **205-565-6554** for any questions I have related to mental health services received through the telemedicine provider/site.

**I have read this document carefully, and my questions have been answered to my satisfaction.**

**Signature of Recipient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ or

**Signature of Parent or Legal Representative** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Telemedicine Consent:**

**Signature of Person Obtaining Consent** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_ Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Facility Name:**  Smith Counseling Services dba MBH Wellness Clinic

**Facility Address:** 100 Century Park S, Suite 102 Birmingham, AL 35226 or 401 4th Ave S, Jasper, AL 35501