FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER
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CONSENT FOR TELEHEALTH SERVICES

Patient Registration Form 300-7 (Rev. Apr 2023)

PATIENT NAME (FULL LEGAL NAME) _____ HEALTH RECORD NUMBER (HRN) _____

The purpose of this form is to obtain your consent to participate in a telehealth consultation in connection with your healthcare services provided by the Fallon Tribal Health Center (FTHC). This service is not required and is only used upon mutual agreement between the provider and patient/client. Telehealth services are subject to the following:

- Telehealth services are not the same as an in-person visit, as you will not be in the same room as your provider. If your provider determines that telehealth is not adequate for a particular issue, the provider may choose to terminate the session and request an in-person session.
- Telehealth services **must** be scheduled in advance.
- Telehealth services provided via computer should be accessed through a safe and secure connection. Be sure to use a computer that is in a confidential or private area.
- If telehealth services cannot be conducted due to technical difficulties, you should immediately contact your provider to schedule a new session.
- Telehealth services are not appropriate for emergencies.
- Telehealth services do not replace in-person appointments and your provider may require an in-person before continuing with telehealth services.
- Some service providers may retain certain personal information, including contacts, addresses, and other information you provide. Please review the provider's privacy policy if you have any questions.

Using telehealth services is entirely voluntary and will not impact the quality of care you receive from the FTHC should you decide not to use these services. The FTHC is not liable for any claims and/or damages arising from following:

- Interruption in the ability to conduct services due to technical difficulties/maintenance, or system failure.
- Access by friends, family members or other persons who may enter on your side during a session.
- Breaches of privacy and security due to the fault of the third-party videoconferencing provider.

I understand the risks associated with telehealth services. I understand that electronic communication methods can be misdirected to or intercepted and disclosed by unintended third parties and may not be a confidential form of communication. I understand and agree that electronic communication is being used for my convenience and the FTHC does not warrant the confidentiality or security of this transmission.

PATIENT/CLIENT ACKNOWLEDGEMENT

I hereby certify that I have read all of the provisions regarding telehealth services, have had it explained to me to my satisfaction, and have received a copy of this Consent for Telehealth Services. I further certify that I am the patient or legally authorized by the patient to accept the terms of this form, and I know and understand the contents thereof.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN _____ DATE SIGNED _____