Prairie Counseling Services
1460 W Main Street, Suite 150
Sun Prairie, WI 53590
(608)837-4814

Informed Consent for Telemedicine/Phone Services

Client Name: _____ Date of Birth: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Prairie Counseling Services providing health care services to me via telemedicine/telephone.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

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. I may revoke my consent in writing at any time by contacting at Prairie Counseling Services. As long as this consent is in force (has not been revoked) Prairie Counseling Services may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Client (or person authorized to sign for client is a minor):

_____ Date:_____

EMAIL: _____

If authorized signer, relationship to client: _____

Witness: _____ Date: _____