Telehealth: What to Expect

Rappahannock County School District is working in partnership with specialists at Valley Health to offer you telehealth services.

What is Telehealth?

Telehealth is the exchange of medical information from one site to another via electronic communications. The telehealth service offered to you will allow you to have a medical appointment with a specialist via secure and interactive video equipment. You will be able to speak in real-time with the specialist during your telehealth appointment.

Is Telehealth Safe?

Yes, all telehealth sessions are secure, encrypted and follow the same privacy (i.e. HIPAA) guidelines as traditional, in-person medical appointments. Your telehealth appointments will always be kept confidential. In addition, telehealth appointments are NEVER audio or video recorded without the patient's consent.

Can I Choose Not to Participate?

Of course, with this program you have been offered the option of seeing a specialist via secure and interactive video equipment within your primary care office. It is your choice to follow this referral.

Things to Remember about Your Telehealth Appointment:

1. On the day of your appointment the patient will check-in with the school nurse. The school nurse will call the parent/guardian to alert them of the appointment
2. At the time of your appointment, a nurse or medical assistant will escort you into the telehealth patient room.
3. If you have any questions before or after the session, you may ask the office staff at Valley Health.
4. The *Telehealth New Patient Packet* must be completed prior to scheduling your first telehealth appointment. You must complete these forms to schedule your first appointment:
    - *Telehealth Consent* form
    - Any other forms/consents the spoke/patient or hub/specialist site or legal team require, including the *Notice of Privacy Practices*, *Patient Rights and Responsibilities* form and the *HIE Consent* to View form.
5. If you are prescribed medication(s) by the specialist you will be able to pick it up directly at your pharmacy of choice as the specialist will either phone in or electronically prescribe your medication(s)

If you have any questions or concerns after reading this form, please contact Rappahannock County Elementary School: 540-227-0200

Telehealth Consent Form

1. I authorize Rappahannock County School District and Valley Health to allow me/the patient and/or my child to participate in a telehealth (video-conferencing) service with Valley Health
2. The type of service to be provided by via telehealth is pediatrics and family medicine
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telehealth healthcare provider.
4. My/the patient's physician/therapist has fully explained to me the nature and purpose of the video-conferencing technology and has also informed me/the patient of expected risks, benefits and complications (from known and unknown causes), possible discomforts and risks that may arise during the telehealth session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The possible risks of not using telehealth sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telehealth service if we believe that the video-conferencing connections are not adequate for the situation.
6. I understand that the telehealth session will not be audio or video recorded at any time.
7. I agree to permit my/the patient's healthcare information to be shared with other individuals for scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telehealth service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telehealth services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.
8. I acknowledge that I have the right to request the following:
    a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
    b. Asking non-medical personnel to leave the telehealth room at any time if not mandated for safety concerns, or
    c. Termination of the service at any time.
9. When the telehealth service is being used during an emergency, I understand that it is the responsibility of the telehealth provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.
10. It is the responsibility of the telehealth provider to conclude the service upon termination of the video-conference connection.

11. I/the patient understand(s) that my/the patient's insurance will be billed by both the local healthcare provider **and** the telehealth healthcare provider for telehealth services. I/the patient understand(s) that if my insurance does not cover telehealth services I/the patient will be billed directly by both the local healthcare provider **and** the telehealth care provider for the provision of telehealth services.
12. My/the patient's consent to participate in this telehealth service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I/the patient acknowledge the telehealth's program no-show policy which states that I/the patient will be discharged from the telehealth program if I/the patient no-show for two, consecutive telehealth appointments, without prior contact to the scheduling staff at spoke site.
15. I confirm that I have read and fully understand both the above and the *Telehealth: What to Expect* form provided. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian Signature*	**Print Name**
Relationship to Patient (if required)	**Date**
Witness	**Date**
Interpreter (if required)	**Date**

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risk of and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Provider's Signature	**Date**

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD