Community Action Partnership
of North Central Missouri (CAPNCM)
1506 Oklahoma Avenue ~ Trenton, MO 64683
Phone: 1-855-290-8544 ~ Fax: 1-844-503-1872
Relay Missouri: 1-800-735-2966
Website: www.capncm.org ~ Email: contactus@capncm.org

INFORMED CONSENT FOR TELEHEALTH SERVICES

Green Hills Community Action dba Community Action Partnership of North Central Missouri

Telehealth:
Telehealth and Telemedicine are two terms used synonymously and interchangeably. Telehealth is the use of electronic information and telecommunications technologies (video and/or audio) to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications. Providers may include certified nurse practitioners, certified nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, physician assistants and/or physicians. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits of Telehealth:

- Improved access to high-quality family planning services by enabling client to remain at a remote site (home) while receiving professional care from a healthcare provider.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant healthcare provider.

Possible Risks:
As with any medical procedure, there are potential risks with the use of telehealth. These risks include, but may not be limited:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the healthcare provider.
- Potential risks to the technology, including interruptions, unauthorized access and technical difficulties.
- Telehealth based services may not be as complete as face-to-face services.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reactions, or other judgement errors.

I, ___________________________, hereby request receipt of family planning services and treatment to be performed by members of the medical staff of **GHCAA/CAPNCM** via telehealth. In requesting family planning services, I understand and agree that:

Family planning services are being requested on a voluntary basis. Family planning services include contraceptive services including emergency contraception, STI testing and treatment, risk reduction counseling and uncomplicated gynecological conditions, as requested by me and provided based upon medical necessity.

I understand that the acceptance of family planning services is not a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program offered by **GHCAA/CAPNCM.**

The financial cost for family planning services may be covered in part or whole, depending upon an income assessment performed by agency personnel, through a Title X grant provided to **GHCAA/CAPNCM** through the Missouri Family Health Council, Inc. Payment for family planning services not covered by Title X funds are generally expected to be paid at the time service is rendered; however, family planning services cannot be denied if I cannot afford to pay for these services today.

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Additional services may be requested by myself and provided at my own expense. I agree to be financially responsible for services or treatment requested that are provided outside the scope of the family planning project. **GHCAA/CAPNCM** will inform me of any charges due and payment requirements prior to rendering any additional services.

Information about the family planning services provided to me will be shared with Missouri Family Health Council, Inc. for use in generating statistical reports that evaluate the family planning program.

Information regarding the family planning services provided may also be shared with individuals who need your information to provide care and services such as labs and pharmacies, and for the coordination of payment with third party payers. See our HIPAA policies for full disclosure on how your information may be shared.

I understand that personal identifiable medical information about me is confidential and that under federal law (Section 7 of the Privacy Act of 1974, 42 USC 405) it states that the disclosure of my social security number is voluntary, and if I refuse to disclose my social security number, I will not be denied family planning services.

If tests performed for STIs are positive, state law requires that the results be reported to the state Department of Health.

Under HIPAA, all services provided are considered confidential meaning that information about the services today are only shared with individuals who need your information to provide care and services such as labs, pharmacies, and for the coordination of payment with third party payers. Information cannot be released to other third parties without your written authorization. If you wish to have information release to other third parties, please complete a records release authorization form.

I understand I have rights as a client to be treated with respect in a nonjudgmental, non-discriminatory manner. I also understand I can file a grievance with **GHCAA/CAPNCM** if I feel my rights have been violated. I understand any staff member can give me more information and the address of the clinic director if I wish to file a grievance. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. If applicable, I authorize **GHCAA/CAPNCM** to bill any insurance available and accept assignment of benefits payable directly to **GHCAA/CAPNCM**. I understand that by exchanging this information, an explanation of benefits will be sent to the policyholder's address.

I have had the alternatives to telehealth consultation explained to me, and I am choosing to participate in a telehealth consultation.

I have read and understand the information provided above regarding telehealth, have discussed it with my healthcare provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care.

________________________	__________	______________________________	________
Client signature	Date	Witness signature	Date