Psychological Associates of Yankton, LLC

Taryn S. Van Gilder-Pierce, Ph.D. – Clinical Psychologist
William D. Pierce, Ph.D. – Clinical Psychologist
Alexandra Pagel, Psy.D. – Psychological Assistant

Telehealth Patient Consent Form

Patient Name: _____
Date of Birth: _____ Email: _____
Provider Name: _____
I agree to receive this health care service as a telehealth service. I understand that the health care practitioner _____ is located at another facility, Psychological Associates of Yankton, LLC 2703 Fox Run Parkway Suite 200, Yankton, SD 57078.

A telehealth service means that my visit with a practitioner at the distant site will happen by using the Doxy.me system, a HIPPA compliant platform to ensure privacy. This consent is valid for six months for follow-up telehealth services with the health care provider.
I also understand that:

-I can decline the Telehealth service at any time without affecting my 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 a health care practitioner in-person if I decline the Telehealth service.
-If I decline the Telehealth services and in-person services with my provider, or my provider is not available, alternatives are as follows: **see another provider at Psychological Associates of Yankton or seek alternative providers in your community**
-The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
-The information from the Telehealth service (images that can be identified as mine or their medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.
-I will be informed of all people who will be present at all sites during my Telehealth service
-I may exclude anyone from any site during my Telehealth service.
-I may see an appropriately trained staff person or employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this in not available.
-I also understand that my insurance will be billed for this visit with consulting health care provider, _____, and that I may be billed for what my insurance does not cover, depending upon the provider. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months and will be renewed after_____.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date

2703 Fox Run Parkway, Suite 200, Yankton, SD 57078
(605) 665-0258