

TELEHEALTH CONSENT FORM

Patient Name:	
Date of Birth:	
Medical Record Number:	
Location of patient (Designated Location): Kootenai Behavio	oral Health, 2301 N. Ironwood Pl., Coeur d'Alene, ID 8381
Provider performing services: Dr. Lauren Boydston, MD	
States in which provider is licensed: Idaho, Washington	
Provider location: Seattle, WA	
Provider contact number: 208-625-4800	
While at the above Designated Location, you may have a You will be able to see and hear the doctor, and the doctor were in the same room. Although not physically present of nursing staff and other providers to provide high quality of seeing a provider on video conference technology, you face—to—face encounter. No part of the encounter will be during the visit in order to help operate the video equipmed As Kootenai Health staff, all individuals present will maintal	ctor will be able to hear and see you, just as if you on the unit, the Provider will coordinate closely with care. At any time, if you are not comfortable with a may request to instead be seen in a traditional e recorded. Others may also be present with you ent or in order to maintain your safety in the room.
 Expected benefits: You will have access to a specialist in the appropriate Continuity of care, if you have already seen or will be the unit. 	
Potential risks:	
 You may be required to see another provider if it is fe was not sufficient to assess you or provide adequate 	
Technical difficulties: • Although safety measures have been implemented to possible that in very rare instances security protocols information.	
I hereby consent to participate in telemedicine visit(s) under the risks and benefits of telemedicine, and I've had my questi will be effective for reoccurring visits, and will be re-evaluated	ions regarding the procedure explained. This consent
Signature of patient / legal guardian Dat	te Time
Name of person signing for patient (if applicable)	not signed by patient, indicate relationship

KOOTENAI HEALTH Coeur d' Alene, Idaho

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TELEHEALTH CONSENT FORM

Patient Name:			
Date of Birth:			
Medical Record Number:			
Location of patient (Designated Location): Kootenai Behavioral Health, 2301 N. Ironwood	Pl., Coeur d'Alene, ID 8381		
Provider performing services: <u>Dr. John Helsell, MD</u>			
States in which provider is licensed: Idaho and New Mexico			
Provider location: Coeur d'Alene, Idaho			
Provider contact number: 208-625-4800			
While at the above Designated Location, you may have a clinical visit using video conferencing ted You will be able to see and hear the doctor, and the doctor will be able to hear and see you, just were in the same room. Although not physically present on the unit, the Provider will coordinate clo nursing staff and other providers to provide high quality care. At any time, if you are not comforted seeing a provider on video conference technology, you may request to instead be seen in a triface—to—face encounter. No part of the encounter will be recorded. Others may also be present during the visit in order to help operate the video equipment or in order to maintain your safety in the As Kootenai Health staff, all individuals present will maintain the confidentiality of any information obtains			
 Expected benefits: You will have access to a specialist in the appropriate field. Continuity of care, if you have already seen or will be seen by the provider for a the unit. 	face-to-face visit on		
 Potential risks: You may be required to see another provider if it is felt that the information obtain was not sufficient to assess you or provide adequate care. 	ined via telemedicine		
 Technical difficulties: Although safety measures have been implemented to ensure that this video compossible that in very rare instances security protocols could fail, causing a breat information. 			
I hereby consent to participate in telemedicine visit(s) under the conditions described in the risks and benefits of telemedicine, and I've had my questions regarding the procedure will be effective for reoccurring visits, and will be re–evaluated on an annual basis.			
Signature of patient / legal guardian Date Time	_		
Name of person signing for patient (if applicable) If not signed by patient, indica	ate relationship		

KOOTENAI HEALTH Coeur d' Alene, Idaho

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Name of person signing for patient (if applicable)

TELEHEALTH CONSENT FORM

Patient Name:	
Date of Birth:	
Medical Record Number:	
Location of patient (Designated Location): Kootenai Behavioral Health, 2301 N. Ironwood Pl., Coeur d'Ale	ne, ID 83814
Provider performing services: <u>Dr. Bruce Miewald, MD</u>	
States in which provider is licensed: Idaho, Montana, Pennsylvania	
Provider location: Coeur d'Alene, Idaho	
Provider contact number: 208-625-4800	
While at the above Designated Location, you may have a clinical visit using video conferencing te You will be able to see and hear the doctor, and the doctor will be able to hear and see you, just were in the same room. Although not physically present on the unit, the Provider will coordinate cle nursing staff and other providers to provide high quality care. At any time, if you are not comfor seeing a provider on video conference technology, you may request to instead be seen in a face—to—face encounter. No part of the encounter will be recorded. Others may also be present during the visit in order to help operate the video equipment or in order to maintain your safety in As Kootenai Health staff, all individuals present will maintain the confidentiality of any information of	t as if you losely with rtable with traditional t with you the room.
Expected benefits:	
 You will have access to a specialist in the appropriate field. Continuity of care, if you have already seen or will be seen by the provider for a face-to-face with the unit. 	visit on
Potential risks:	
 You may be required to see another provider if it is felt that the information obtained via teleme was not sufficient to assess you or provide adequate care. 	edicine
Technical difficulties:	
 Although safety measures have been implemented to ensure that this video conference is se possible that in very rare instances security protocols could fail, causing a breach of privacy o information. 	
I hereby consent to participate in telemedicine visit(s) under the conditions described in this document. I the risks and benefits of telemedicine, and I've had my questions regarding the procedure explained. The will be effective for reoccurring visits, and will be re–evaluated on an annual basis.	understand nis consent
Signature of patient / legal guardian Date Time	

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KOOTENAI HEALTH
Coeur d' Alene, Idaho

If not signed by patient, indicate relationship

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