



30 S. Valley Rd. Ste. 101C, Paoli, PA 19301
Phone: (267) 747-3669 Fax: (484) 383-0300

Telehealth Informed Consent:

1. I understand that telehealth involves the communication of my/child's medical and developmental information in an electronic or technology-assisted format (phone, videoconferencing, and others).
2. I understand that I may opt out of telehealth visits at any time. This will not change my ability to receive future care at RiseNow Autism Innovations LLC.
3. I understand that telehealth services can only be provided to patients (including my child) who are physically located in a state where the provider is licensed at the time of the visit. It is my responsibility to notify RiseNow Autism Innovations LLC if I/my child will no longer be in a state where the provider is licensed.
4. I understand that telehealth billing information is collected in the same manner as in-person visits, and visit fees are the same for face-to-face and telehealth visits at RiseNow Autism Innovations LLC.
 - a. I understand that if technology fails for a videoconferencing session, the visit may be moved to a phone appointment or potentially rescheduled, and there will be no change in visit fees (I will still be responsible for the full visit fee). This may affect the accuracy of diagnostics or make diagnosis complicated, potentially requiring a follow-up visit for continuation.
5. RiseNow Autism Innovations LLC is an out-of-network provider and does not participate in any insurance plans, Medicare, Medicaid, or Medical Assistance programs. It is my responsibility to determine whether my insurance company reimburses for telehealth appointments. Our fees do not change regardless of insurance reimbursement decisions.
6. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
 - a. It is easier for electronic communication to be forwarded, intercepted, or changed without my knowledge despite reasonable measures.



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b. Electronic systems accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.

c. Despite reasonable efforts, transmission of medical information could be disrupted or distorted by technical failures.

d. Telehealth visits could be accessed without authorization despite reasonable efforts to prevent this.

e. Providers will not be able to perform a full in-person physical examination or certain assessments that may be part of standard care.

7. I agree that information exchanged during my/child's telehealth visit will be maintained by doctors, nurse practitioners, administrators, and other staff involved in care at RiseNow Autism Innovations LLC.

8. I understand that medical information is governed by federal and state laws that apply to telehealth.

9. I understand that non-HIPAA-compliant platforms (Skype, FaceTime, etc.) are not used by RiseNow Autism Innovations LLC; only secure, HIPAA-compliant platforms are utilized.

10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications.

11. The healthcare provider is not responsible for breaches in confidentiality caused by me or by an independent third party.

12. I agree that I have verified my identity and current location in connection with telehealth services. Failure to comply may result in termination of the visit.

13. I understand that I have the responsibility to verify the identity and credentials of the healthcare provider rendering care via telehealth.

14. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.



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15. I understand and agree that a medical/developmental evaluation via telehealth may have limitations. I agree to accept responsibility for following the provider's recommendations, including any suggested in-person follow-up or additional testing.

16. I understand that electronic communication may be used to communicate sensitive medical or developmental information. I also understand that I will receive my choice of text message, email, or both (my preference) for links to appointments.

17. I understand that my/child's healthcare provider may forward information to an authorized third party with my consent. I have informed the provider of any information I do not wish to be transmitted electronically.

18. By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information during a telehealth visit.

19. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis.

20. To the extent permitted by law, I agree to waive and release RiseNow Autism Innovations LLC and its providers from any claims I may have about the telehealth visit.

21. I understand that electronic communications should never be used for emergency communications or urgent requests. In the case of an emergency, I will call 911 or go to the nearest emergency room.

22. I understand that in the event my child's provider determines that telehealth is no longer clinically appropriate or safe, care may be discontinued or transitioned to an outside, in-person provider.

I certify that I have read and understand this agreement and that all of my questions have been answered to my satisfaction.

For electronic communication between all staff at RiseNow Autism Innovations LLC and:

Name_____

Signed_____

Date_____