

Wyoming Medicaid Telehealth Patient Consent Form

I (Client Name) _____ agree to receive this health care service (type of service) _____ as a telehealth service. I understand that the health care provider (name) _____ is located in another location (facility name and address) **Park Ridge Behavioral Health Care, 6500 E. 2nd St., Casper, WY 82604**. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. 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 healthcare provider in-person if I decline telehealth service.
- If I decline the telehealth services, the other options/alternatives available to me, including in person services are as follows:

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- The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
 - I will have access to all medical information resulting from the telehealth service as provided by law.
 - The information from the telehealth service (images that can be identified as mine or other 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 in an urgent need arises or I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient: _____ Date: _____

Or

Signature of Parent or Legal Representative: _____ Date: _____

Telehealth Consent:

Signature of Person Obtaining Consent: _____ Date: _____

Facility Name: **Park Ridge Behavioral Health Care**
Facility Address: **6500 E 2nd St., Casper, WY 82604**