BRETT LEIMKUHLER, Ph.D.
The Center For Neuropsychology & Learning Disorders, Inc.
Comprehensive Diagnostic Assessment for Children, Adolescents, and Adults

Informed Consent for Telehealth Appointments and Text Messages

Patient Name_____Date of Birth_____

I, _____, hereby consent to engage in Telehealth Services with Brett Leimkuhler, Ph.D., at the Center for Neuropsychology and Learning Disorders in Wakefield, Rhode Island. I also consent to receive SMS text messages from Dr. Leimkuhler and CNLD, Inc. containing non-identifying and non-clinical information, e.g. for appointment confirmations or other non-clinically related questions.

I understand that Telehealth (or Telemedicine) is the use of electronic information and communications technologies by a healthcare provider to deliver services to an individual who is located at a different site than the provider. I also understand that SMS text messages are non-encrypted.

I understand that the laws of privacy and confidentiality of medical information also apply to Telehealth.

I understand that I will be responsible for any copayments or coinsurances that apply to my Telehealth visit.

I understand that there are potential risks to participating in Telehealth, including but not limited to the possibility that the transmission of my information could be disrupted or distorted by technical failures, and the transmission and/or storage of my information could be accessed by unauthorized persons. There is also a risk that services could be disrupted or distorted by unforeseen technical problems.

Please note: The use of a secure, HIPAA-compliant platform such as the Professional version of Zoom used by Dr. Leimkuhler is designed to reduce these risks.

In addition, I understand that there is a risk of being overheard by persons in my vicinity if I am not in a private room while participating in a Telehealth visit. I am responsible for providing the necessary computer and Internet access, and for arranging a private location that has sufficient lighting and is free from distractions or intrusions for my Telehealth session(s). It is the responsibility of Dr. Leimkuhler to do the same on his end.

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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. I may revoke my consent orally or in writing at any time by contacting the Center for Neuropsychology and Learning Disorders, Inc. As long as this consent is in force and has not been revoked, Dr. Leimkuhler may provide healthcare services to me via Telehealth without the need for me to sign another consent form.

I am entitled to a copy of this consent form upon request.

I have read, understand, and agree to the information provided above regarding Telehealth services and SMS text messages.

_____ Date_____

Signature of Patient
(Or person authorized to sign for the patient)

_____

Relationship to Patient