Instructions for filling out the Telehealth Consent Form

Beginning October 1, 2017 Wyoming Medicaid will allow the client's home to be a valid Origination site. Written client consent is required.

Completion: The appropriate person at either the client's site or the health care practitioner site completes the form and obtains the client's signature prior to the services.

Distribution: The original form is completed by the provider of the telehealth service and is retained in the client's medical record. A copy is also given to the client or parent/guardian.

Field	Action
Client Name	Enter the client's name
Type of Service	Define the service to be provided as a telehealth service on the second line
Provider Name	Enter the name of the health care practitioner who will be seeing the client from the distant site
Facility Name and Address	Enter the facility name and address of the distant site where the health care practitioner is located
Alternative Services	Describe in writing any other options that are available to the client
Signature and date	The client, parent or legal representative must sign and date the form
Signature of Person Obtaining Consent	Person obtaining consent must sign and date the form
Facility Name	Enter the Facility for the person obtaining consent
Facility Address	Enter the Facility address for the person obtaining consent

Wyoming Medicaid Telehealth Patient Consent Form

Wyoming Department of Health

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)_____. 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.

Obstetrics and Gynecology

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Casper Women's Care 770 East 2nd Street Casper, Wyoming 82601

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 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:

_____

_____

- 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 information 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: Casper Women's Care

Facility Address: 770 East 2nd Street Casper, Wyoming 82601