***Video-enhanced Therapy***

**Participant Agreement**

I understand that Video-enhanced Therapy (VET) is an option to me as part of my treatment to assist in the observation of my prescribed doses in place of in-person scheduled face-to-face visits for the purpose of directly observed therapy.

I understand that:

* I will be in contact for VET using my own smartphone or computer/internet connection with my health care worker each time I am scheduled for TB medicine.
* I will need to use either an application suggested by the health department or Google Chrome on my smart phone, depending on the type of phone in use. There will be no charge to me for using the application. There may be data charges from my phone provider.
* I will need to be in a private or remote location during the call so that my private information is not heard by others in my location.
* The health care worker will ensure that their location is in a private or remote location so that it will not be overheard by others.
* The smartphone /computer/wifi connection may be to an unsecure network.
* My name or diagnosis will not be mentioned on the call. I will use an identifier or “nickname.”
* I will be asked about side effects to the medicine and any symptoms of my diagnosis.
* The video call will not be recorded by the health department or the Doxy.me app.

 In order to participate in VET, I understand I MUST:

* Provide my phone number to use for video therapy.
* Be available to receive a text message and phone call, then activate the video screen.

I will then take all my prescribed medication without exception during the video contact.

* Keep my face and my medicine in view during the video call as I swallow the medicine.
* Keep all scheduled clinical appointments and adhere to my video call schedule to continue in the program.
* Promptly provide all clinical specimens (blood, sputum, etc.) and submit to all procedures (chest x-ray, etc.) as requested by my health care worker to assist assessment of my current health status.
* Notify the health care provider immediately of any changes in my address or telephone number.

I understand that failure to follow **ANY** of the conditions of this agreement mayresult in stopping the video calls and a return to in-person visits for directly observed therapy.

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Participant Printed Name Signature Date

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Witness Printed NameSignature Date