Myers Health and Wellness LLC

Consent for Telehealth

Definition of Telehealth:

Telehealth involves the use of electronic communications to enable Myers Health and Wellness LLC clinicians to connect with individuals using live interactive video and audio communications. I understand that I have the rights with respect to telehealth: 1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. Copy of our Office Policies and Therapeutic Informed Consent can be provided. 2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth during my care at any time, without affecting my right to future care or treatment. 3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons.

The standard copay and/or deductibles would apply. If insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company. I have read and understand the information provided above regarding telehealth, have discussed it with my clinician and all my questions have been answered to my satisfaction.

I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein.

By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Patient Name: ____

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Patient Signature /Date

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