Telehealth Consent Form

Welcome to my practice! I look forward to our work together. This Telehealth Consent Form outlines your consent to our communication about your health through video and/or telephone appointments. Please read it carefully and make note of any questions you might have so that we can discuss them together before signing. By signing below, you are agreeing to the terms of this Telehealth Consent Form.

I _____ am the client who voluntarily consent to engage in Telehealth services ("Telehealth") with Wagala Compound LLC (the "Practitioner"). In exchange for participation in these services, I understand and consent to the following:

1. Telehealth Appointments.

"Telehealth" includes consultation, recommendations, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications for purposes of evaluating, diagnosing, and treating my medical situation and any health concerns.

Telehealth is provided by interactive video and audio and therefore it may or may not involve direct, face to face, communication, and that there are benefits and limitations to Telehealth.

I understand that I will be informed of the identities of everyone present during Telehealth appointments and of their purpose for attending the appointments.

2. Use of Video/Audio Technology.

I understand that prior to my first Telehealth appointment it is my responsibility to set up access to the Telehealth platform on my computer or mobile device (such as HIPAA-compliant

Zoom or another HIPAA-compliant EMR or platform with live simultaneous video and/or live simultaneous audio capability) and be familiar with using the appropriate video and/or audio technology to participate in the Telehealth appointment(s).

I agree to use my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network, if employed by someone other than myself.

Technical issues may arise before or during use of Telehealth, and on occasion, my appointments may not start or end at agreed-upon times. In addition, on occasion, other communication channels may be used in case of internet connectivity or other issues.

3. Benefits and Risks of Telehealth.

I understand that I may expect the anticipated benefits from the use of Telehealth in my care, there are also risks and I'm aware that no results can be guaranteed or assured.

a. Possible Benefits. I understand that by using Telehealth, there are potential benefits, which included, but may not be limited to:

- Improved convenience and access to health care services by enabling me to be at home or elsewhere than my medical practitioner's office.
- The ability for my medical practitioner to obtain test results, expertise and/or consults, if applicable, from other practitioners in other locations, if needed.
- More efficient and time-saving evaluation and management of my heath conditions.

b. Possible Risks. I understand that by using Telehealth, there are potential risks which include, but may not be limited to:

- The information transmitted through video/audio may not be sufficient to allow for appropriate assessment, evaluation, or decision-making by my medical practitioner, and may still result in me needing to come see the practitioner for an in-person medical appointment.
- Problems or failures with the technology could lead to delays in medical evaluation and/or treatment.
- In very rare instances, security protocols for technology could fail, causing a breach of privacy of my personal health information.
- In rare cases, a lack of access to complete health records may result in negative results, allergic reactions or other judgment errors.

4. Exchange of Medical Information.

I understand that Telehealth also involves the communication of my personal health information, both orally and visually. The Practitioner has my permission to access my medical records for the purpose of Telehealth and ongoing documentation, evaluation and analysis.

I understand that the laws that protect privacy and the confidentiality of health information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to researchers or other entities without my consent. All of my personal health information and any other identifying information will be kept private.

I understand that Telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.

The exchange of information through Telehealth may not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

5. My Rights and Responsibilities.

I have the right to withhold or withdraw my consent to the use of Telehealth at any time, without affecting my right to future care or treatment.

I understand that I have the right to inspect all information obtained and recorded during a Telehealth appointment or interaction, and I may receive copies of this information for a reasonable fee.

I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My medical practitioner has explained the alternatives to my satisfaction.

I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.

I understand that my insurance plan may not encompass Telehealth services, or my medical practitioner may not accept insurance. In cases where my insurance plan does not cover any expenses which have been incurred, I agree to be personally liable to cover these expenses.

I understand that the e-signing of this document is a legal and valid signature.

I have read and understand the information provided above, discussed it with my medical practitioner or their assistant(s), and all of my questions have been answered to my satisfaction. I give my informed consent for the use of Telehealth in my care by signing below.

Signature: _____

Printed Name: _____

Address:_____
City: _____ State: _____ Zip: _____
Date: _____