Telehealth Consent Form

1. I _____(patient name) voluntarily consent and authorize **Great Plains Geriatrics** to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. Telecommunications with patients will not be recorded and stored.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.
6. I agree to allow **Great Plains Geriatrics** to file necessary insurance claims for reimbursement for the medical care and treatment that I receive.
7. I understand:
    - That my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
    - **Great Plains Geriatrics** may be required to share and provide medical record information to my insurance company.
8. I understand:
    - I have the right to refuse any procedure or treatment at any time.
    - I have the right to discuss all medical treatments regarding purpose, potential risks and benefits of any treatment or testing with my clinician.
    - I can withdraw my consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Relationship to Patient

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