

Telehealth Treatment Consent

Information and Informed Consent for Telehealth Treatment

Telehealth is live two - way audio and video electronic communications that allows Provider and Patient to meet outside of a physical office setting.

Patient Understanding

I understand that Telehealth health services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the Telehealth health sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of patient information also apply to Telehealth and that no information obtained in the use of Telehealth that identifies me will be disclosed to other entities without my consent.

I understand that Telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.

I agree that the Provider and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my Provider may discontinue the Telehealth sessions at any time if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a Telehealth session, then my Provider may call emergency services and/ or my emergency contact.

I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to Telehealth services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my Provider, or I will make additional plans with my Provider ahead of time for re -contact.

I understand a "no show" or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment.

I understand my Provider will advise me about what Telehealth health platform to use and she will establish a video conference session.

Patient Consent

☐ I hereby give my informed consent for the use of Telehealth in my care.

Patient Name:

Date of Birth:

Email:

Phone Number:

Patient (Guardian) Signature: