<u>Telehealth Patient Verbal Consent Form</u>

PATIENT NAME: ____

DATE OF BIRTH: ____

The purpose of this form is to obtain consent to participate in a Telehealth service in connection with the following type of visit:

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A Telehealth service means that my visit with the provider at the distant site will happen by using either appropriate audio and/or visual equipment, encrypted messaging through an EMR portal or web platform, secure e-mail or secure texting app.

I also understand that:

- Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth service, however, there are still potential risks of breach of information based on technology limitations.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- I will be informed of all people who will be present during my Telehealth visit.
- I may see an appropriately trained employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
- I also understand that my insurance will be billed for this visit, that there may or may not be co-payments and services applied to a deductible that I would be responsible for.
- If I am a new patient, I may be asked to provide photo identification and insurance information to be photographed by the provider/practice in a secure method. For established patients, this authentication would be at the discretion of the provider/practice.

I have read this document carefully, and my questions have been answered to my satisfaction. I agree to participate in this Telehealth visit. I understand that a copy of this consent will be mailed to me to verify this process.

____ ____________________

Signature of Person Obtaining Consent Date

____ ____________________

Witness Date

Facility Name and Address____