**Telehealth Consent Form**

**Patient Information:** Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction:**
Telehealth involves the use of electronic communications to provide and coordinate healthcare services. The purpose of this form is to obtain your consent for receiving care through telehealth consultations.

**1. Nature of Telehealth Services:**
Telehealth services may include consultation, diagnosis, treatment, follow-up, and education using electronic communications such as video conferencing, phone calls, and secure messaging.

**2. Benefits & Risks:**
**Benefits:**

* Access to healthcare from a convenient location.
* Reduced travel time and costs.
* Improved access to specialized care.

**Risks:**

* Potential for service interruptions due to technical issues.
* Limited physical examination capabilities.
* Possible unauthorized access due to security risks.

**3. Confidentiality & Privacy:**
All telehealth services will comply with HIPAA and other relevant privacy laws. Reasonable measures will be taken to protect your personal health information, but no system is entirely secure.

**4. Patient Rights & Responsibilities:**

* You have the right to refuse or discontinue telehealth services at any time without affecting future care.
* You are responsible for ensuring a private location for your session.
* You must provide accurate and complete health information.

**5. Emergency Situations:**
Telehealth is not suitable for emergencies. If you are experiencing a medical emergency, call 911 or go to the nearest emergency room.

**6. Financial Responsibility:**
Telehealth services may be billed to your insurance provider. You are responsible for any co-pays, deductibles, or services not covered by your insurance plan.

**Consent Statement:**
I have read and understand the information provided above. I consent to receive healthcare services via telehealth and understand I can withdraw my consent at any time.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_