Patient Consent for Telehealth:

1. I agree to receive health care services via telehealth. I understand that:

    a. I have the right to access services through an in-person, face-to-face visit or through telehealth.
    b. The use of telehealth is voluntary, and I may withdraw my consent or stop telehealth services at any time.
    c. Insurance may or may not provide coverage for transportation to in-person services when other resources have been exhausted.
    d. There may be limitations or risks of receiving telehealth services as compared to in-person visits. For example, the inability for your health-care provider to perform physical exams at time of service.

2. I am of sound mind and have read this document carefully. I understand the potential limitations and risks of receiving services via telehealth, and my questions have been answered to my satisfaction.

Printed Name: _____

Signature: _____ Date: _____