CONSENT FOR TELEHEALTH CARE AND ELECTRONIC COMMUNICATIONS

Below is a copy of the electronic version reviewed/accepted at time of registration

I consent and agree to the following:

1. I consent to receive care through video conferencing technology, or "telehealth." I understand that a telehealth visit will not be the same as a direct patient/provider visit because I will not be in the same location as my provider(s).
2. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes, as well as with other providers involved in my care. I understand that individuals other than my provider may also be present during my visit(s), if needed to operate the technology used for the visit(s).
3. I understand that my telehealth visits will be billable visits. I agree that I will be responsible for any deductibles, coinsurance, and copayments that apply under my insurance plan and that I am responsible for paying the full balance of any telehealth care that is not covered by insurance. I understand that my insurance plan may not provide full payment for all of the telehealth visits I receive.
4. If I choose to provide an email address and/or mobile telephone number below, I also consent to allow my provider, and any clinical and billing staff or partners of my provider, to communicate with me by email and/or Short Message Service ("SMS") text messaging (as applicable) regarding the health care services I receive, appointment confirmations, and payment for those services. I understand that these email and/or text messages contain my health information, including my name, address, date of birth, insurance coverage information, diagnosis, and information related to the services or procedures I receive, including test results.
5. If I choose to provide an email address and/or mobile telephone number below, I certify that I am the user and/or subscriber of the email address and telephone number I provide. I agree to notify my provider immediately of any changes to my contact information (email address or phone number, as applicable). I also understand that messaging and data rates may apply.
6. I understand that my provider will apply reasonable safeguards to protect my health information when conducting my telehealth visit, as well as when communicating with me by email or text message. However, I also understand that these electronic communications may not be encrypted, and that there is a risk that electronic communications may be intercepted, forwarded or read by unauthorized parties.
7. I understand that I am not required to sign this consent form, but I understand if I do not sign this consent, my provider may not be able to provide my care through telehealth.
8. I understand that I have the right to revoke all or part of this consent at any time by sending written notification. I understand that my revocation is not effective to the extent that my provider has already relied on this consent form.
9. Further, any recording of this or future telehealth visits, whether audio or video, is prohibited and I hereby agree not to record the visit in any format with the understanding that failure to comply with this policy may result in discontinuation of my care.

Signed: ____ **Date** _________________________

Printed Name: ___________________________________