Consent of Telehealth Treatment

I ________________________________ (patient's name) hereby consent to engage in Telehealth medical visits with my physician, Dr. ___________.

I understand that "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, we will be connecting using Doxy which is a system that is encrypted to the federal standard and HIPAA compatible.

It is my responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers and hackers could either overhear our communications or have access to the technology that you are interacting with. Additionally, I agree not to record any Telehealth sessions.

During a Telehealth session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. I will ensure that I have a phone with me, and I have provided that phone number.

I understand that I am financially responsible for all services rendered, late cancellations and missed appointments.

Patient name: ________________________________

Patient signature: _____________________________

Today's date: _________________________________

Email address for telehealth visit: ______________________________

Phone number for telehealth visit :_______________________________