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Consent for Telehealth Consultation

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Consent to use Telehealth by Doxy.me, Vsee, SimplePractice or pMD

Telehealth by Doxy.me, VSee, SimplePractice or pMD is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by any sites above are NOT an emergency service and in the event of an emergency, I will call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither above stated sites nor Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by any of the above sites facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all the technical information in the Telehealth by any of the above sites, or that such information is current, accurate, or up to date. I will not rely on my healthcare provider to have any of this information in the Telehealth Service by any of the above sites.
5. To Maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

1. That I have read or has this form read and/or had this form explained to me.
2. That I fully understand the contents including the risks and benefits of the procedure(s).
3. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

By signing below, I am agreeing that I have read, understood and agree to the items contained in this document.

Patient signature (If minor, Parent/Guardian)	Date
Patient Name	Provider's Name