Telehealth Consent Form

Patient Name: ____ Date of Birth:_______________________________

1. I understand that my provider wishes me to engage in a telemedicine visit.
2. My provider has explained to me how the video conferencing technology will be used and how it will not be the same as a direct patient visit.
3. I understand there are potential flaws to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The information shared will only be on a need to know basis explicitly for billing and scheduling.
5. I have had the alternatives to a telemedicine explained to me, and am choosing to participate in a telemedicine visit.
6. I understand that billing will occur from my therapist under the facility of Monarch Mental Health and Wellness.
7. I have had a direct conversation with my provider,, during which I had the opportunity to ask questions in regard to this telemedicine visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

By signing this form, I certify:

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

Signature: ____________________________________ Print: _____________________________________ Date: _______________

Signature of Parent/Guardian:_____________________________Print: ___________________________Date:______________