(YOUR LLC NAME)

# CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that I am voluntarily engaging in a telemedicine consultation with (YOUR SERVICE).
2. I understand that the video conferencing technology and/or phone consultations will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care, decreasing costs, and allowing visits to be performed from the comfort of my home.
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 understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that if there is another individual present during the telehealth consultation that I will be informed of their presence and I will also disclose if there is another individual with myself. It is agreed that these individuals will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
6. I understand that the alternative to a telemedicine consultation is to forgo evaluation and treatment with (YOUR NAME AND/OR LLC NAME) and to seek out an in-person evaluation elsewhere. Thus, I am freely choosing to participate in a telemedicine consultation.
7. I understand that telemedicine has limitations in regard to the physical examination. I understand that the physical exam portion of the care provided through (YOUR LLC NAME) will be limited to inspection via video conferencing and some parts of the exam such as physical tests, examination of certain body parts, and vital signs may be conducted by individuals at my location at the direction of the consulting health care provider or not done at all.
8. Telemedicine services offered through (YOUR LLC NAME) is not an Emergency Service and in the event of an emergency or urgent medical issue, I will use a phone to call 911, go to the emergency department, or go to an urgent care.
9. To maintain my privacy, I will not share telemedicine login information or video conferencing links with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form explained/read to me and I understand its contents including the risks and benefits of telemedicine.
- That I have had the opportunity to ask questions and have had them answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

(This will need to be integrated into the clinical portal or website of your choosing for signing consent forms).