Informed Consent for Telehealth Consultations

To better serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means that you may be evaluated and treated by a health care provider or specialist from a distant location through forms of communication such as (but not limited to) video visits and telephone calls. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. The consulting health care provider or specialist will be at a different location from me. A physician or other health care provider ("presenting practitioner") may be present with me in the room to assist in the consultation.

3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the presenting practitioner and, via video, the consultant. I will give my verbal permission prior to the entry of the additional personnel.

4. The physician or health care provider for whom the on-site examination or treatment is performed (that is, the "presenting practitioner") will keep a record of the consultation in my medical record.

5. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problem.

6. I understand that I have the option to refuse telehealth service at any time.

7. I understand that there are inherent risks with the use of telemedicine platforms and the electronic transmission of health information, including, but not limited to unauthorized access. These risks are mitigated by utilizing HIPAA compliant video platforms but can never be zero.

By signing below, I consent to the use of telemedicine for my care.

Patient Signature:_____ Date:_____

Additional Consents for Communication

1. EMAIL CONSENT: for the purpose of appointment reminders, treatment updates, wellness tips, and other clinic related information email may be utilized as a form of communication.

a. I understand that email may not always be secure and there is always a risk of unauthorized disclosure or access. If I am concerned about this, I should avoid sending sensitive personal health information via email.

b. I have the right to refuse email communication and/ or revoke my consent at any time by notifying the Beyond Urgent Health.

c. Please check off below whether you would like to use email communication:

☐ I DO CONSENT to the use of email for communications.

☐ I DO NOT CONSENT to the use of email for communications.

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2. TEXT MESSAGING: for the purpose of appointment reminders, treatment updates, wellness tips, and other clinic related information text messaging may be utilized as a form of communication.

a. I understand that text messaging may not always be secure and there is always a risk of unauthorized disclosure or access. If I am concerned about this, I should avoid sending sensitive personal health information via text.

b. I have the right to refuse text communication and/ or revoke my consent at any time by notifying the Beyond Urgent Health.

c. Please check off below whether you would like to use text messaging communication

☐ I DO CONSENT to the use of text messaging for communications.

☐ I DO NOT CONSENT to the use of text messaging for communications.

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3. PHONE MESSAGES: Occasionally a phone message may be necessary to communicate medical information. Phone messages left on voicemails are not secure. You have the right to refuse voicemail messages now or to revoke your consent at any time in the future by notifying Beyond Urgent Health.

Please check off below if you consent to voicemails to communicate health information such as (but not limited to) test results, discussions of care, answers to questions.

☐ I DO CONSENT to the use of voicemails for communication of health information.

☐ I DO NOT CONSENT to the use of voicemail for communication of health information.

If you do consent to voicemails, please write the phone number we may leave messages at below.

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By Signing this form, I authorize the methods of telecommunication for my medical care noted above. This consent will remain in effect until revoked.

Patient Signature:_____. Date:_____

Clinic Personnel Signature:_____