First Name: _____ Last Name: _____ DOB:_____

Physician:_____ Date Concent Discussed: _____ Provider Name:_____

Consent for Telehealth/Teletherapy Treatment

I understand that telehealth is the use of electronic information and communication technologies by a health provider to deliver services to an individual when he/she is located at a different site than the provider, and hereby I consent to _____ providing therapy/health related services to me via teletherapy.

I understand that the laws that protect privacy and the confidentiality of medical/therapeutic information also apply to teletherapy. As always, your insurance carrier and billing staff will have access to your records for quality review/audit.

I understand that I will be responsible for any co-payments or insurance that apply to my telehealth sessions.

I understand that I have the right to withdraw or withhold my consent to the use of telehealth in the course of my care at any time, without impacting my right to future care or treatment.

I may revoke my consent orally or in writing at any time by contacting _____at _____. As long as this consent is in force (has not been revoked), _____ may provide health care services to me via teletherapy without the need for me to sign another consent form.

Patient signature (or person authorized to sign for the patient:

Sign Here _____Date:_____

Relationship to the patient (If authorized signer):_____

I acknowledge that I have been offered a copy of this form: (Initials)_____