Telehealth Consent Form

Patient Name: _____ DOB: _____

Provider Name: _____

I hereby consent to receive healthcare services through telemedicine or telehealth platforms provided by Center for Medicine, LLC. I understand telehealth services may involve video conferencing, audio, and/or other electronic communication to connect me with my healthcare provider.

I understand that regular office visit copayments and coinsurance will apply for telehealth. I understand that copayments will need to be collected prior to the telehealth appointment.

I understand that my healthcare provider will make every effort to ensure the security and privacy of my personal and medical information. However, I acknowledge that there are risks associated with electronic communication and that my information could be intercepted or disclosed without my consent.

I understand that my healthcare provider will document my telehealth visit and that my medical records will be maintained in accordance with state and federal regulations.

By signing below, I acknowledge that I have read and understand the information provided in this Telehealth Consent Form and consent to receive healthcare services through telehealth platforms.

Patient Signature: _____

Date: _____