*TeleHealth Informed Consent

Patient Name: *

Date of Birth: *

Desert Foothills Concierge Medicine

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and herby consent to Desert Foothills Concierge Medicine to provide services to me via telehealth.

INITIAL: *

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
Desert Foothills Concierge Medicine does not bill insurance and all payments are paid at the time of service.

You will have access to your medical records in accordance to HIPPA.
I understand that I will be responsible for any service rendered by Desert Foothills Concierge Medicine.

INITIAL: *

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting Desert Foothills Concierge Medicine. As long as this consent is in force Desert Foothills Concierge Medicine can provide health care services to me via telehealth without the need for me to sign another consent form.

INITIAL: *

PATIENT SIGNATURE *

Date Document Signed: *