axiscommunityhealth

INFORMED CONSENT FOR TELEHEALTH APPOINTMENTS

1. I understand that my provider will be at a different location from me when we connect for our appointment.

2. I will be informed if any additional personnel, like a translator, will be present during the telehealth appointment. I will give my verbal permission before the entry of the additional personnel.

3. The provider will keep a record of the telehealth appointment in my medical record.

4. RELEASE OF INFORMATION: I understand that Axis Community Health is authorized to furnish medical information from my medical record to a referring physician, if any, and to any insurance company or third-party payer to obtain payment of the account. Axis Community Health is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

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

6. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk of losing benefits. I do not have to answer any questions that I am unwilling to have heard by other persons or do not feel comfortable answering.

7. I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation. I understand that as with any technology, telehealth does have its limitations. There is no guarantee, therefore, that this telehealth session will eliminate the need for me to see a provider in person.

Patient/Representative Signature _____

Date _____