SPINE & SPORTS
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Patient Consent to Telehealth Services

Telehealth services involve the use of electronic communications to enable health care providers to deliver health care services to patients using interactive video and audio communications. This document outlines the potential benefits and risks associated with telehealth services and confirms your consent to the use of telehealth services in your health care.

I, _____, understand the following:

1. The laws that protect the confidentiality of my personal information also apply to telehealth.
2. 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 or treatment.
3. The same standard of care that would apply to an in-person visit also applies to telehealth.
4. My health care information may be shared with other individuals for scheduling or billing purposes.
5. I consent to the disclosure of records concerning my telehealth interaction to my primary care provider and/or any other healthcare provider deemed necessary/involved in my care.
6. There are certain risks associated with telehealth, including delays in treatment occurring due to deficiencies or failures of equipment, interruptions of services, or other technical difficulties, or the breach of privacy of personal health information caused by failure of security protocols.
7. Certain technical failures may necessitate the rescheduling of my appointment or the continuation of my visit by alternative means.
8. I am responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit, and I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.
9. This document will become a part of my health record.

I hereby give my informed consent for the use of telehealth services in my health care. I have personally read this form (or had it explained to me) and fully understand and agree to its contents. My questions about telehealth services have been answered to my satisfaction, and the risks, benefits, and alternative to telehealth service have been shared with me in a language that I understand. I am located in and will remain in the state of _____ during my telehealth encounter(s).

_____
Patient's Printed Name

_____ _____
Patient's Signature (Parent/Guardian if patient is a minor) Date