KODIAK COMMUNITY HEALTH CENTER

MR #_____
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CONSENT FOR TELEHEALTH SERVICES

Telehealth or "virtual health" services involve the use of audio, video, or other electronic communication technology to allow patients and/or their guardians to interact and consult with a health care provider and review the patients' medical information for the purposes of diagnosis, treatment, follow-up or patient education. I understand that:

1. The telehealth or virtual service will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my provider.
2. These telehealth services are NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
3. To maintain confidentiality, I will not share any links, access codes or login information for my telehealth appointment with anyone unauthorized to attend the appointment.
4. Information transmitted to the provider may not be sufficient to allow the provider to make appropriate medical decisions.
5. Providers cannot conduct certain evaluations during a virtual visit. In some cases this may prevent the provider from providing a diagnosis or treatment or from identifying that I need emergency medical care.
6. The provider may not be able to provide medical treatment for particular conditions remotely, and I may need to follow up with an in-person evaluation.
7. Delays in medical evaluation or treatment could occur due to deficiencies or failures of the technology or electronic equipment used for the virtual visit.
8. Security protocols or safeguards could fail, causing a breach of privacy of personal medical information.
9. Given regulatory requirements in certain jurisdictions, the provider's treatment options, especially pertaining to prescriptions, may be limited.
10. I have the right to withhold or withdraw my consent to virtual visits in the course of my care at any time, which I may exercise by providing notice to KCHC.
11. My insurance will be billed for telehealth or virtual services. If my insurance does not cover these services, I will be billed directly for these services and I accept full financial responsibility for the services, including any co-payments, co-insurance and deductibles.
12. The KCHC policies detailed in the **Consent to Treat and Patient Responsibilities** form that I signed in the KCHC patient registration process apply to these telehealth or virtual services.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the service(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient/Guardian	Printed Name of Patient/Guardian	Date

Printed Name of Patient if Signed by Guardian

Signature of Witness	Printed Name of Witness	Date

Witness name and signature required if patient/guardian consent obtained verbally.