



**TELEHEALTH ACKNOWLEDGEMENT FORM**

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

1. Telehealth is “the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance”. I understand that my healthcare provider, \_\_\_\_\_ has recommended a Telehealth appointment.
2. My healthcare provider has explained to me how the telehealth technology will work. Telehealth appointments will be conducted by video conferencing using Doxy.me, with possible video images, still (high –quality photo) images or by telephone conference. I understand that this appointment will not be the same as a direct patient/provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to the technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the video conferencing connection is not adequate for the session. I understand that I can discontinue telehealth at any time.
4. I understand that my healthcare information may be shared with other individuals for consultation, scheduling or billing purposes. The above mentioned people will all maintain confidentiality of information obtained.
5. I understand that some parts of the exam, involving physical tests may deem that a telehealth visit is not the best option at this time.
6. In an emergency situation, I understand that the telehealth provider may direct me for emergency medical services, such as at an emergency room. The telehealth provider’s responsibility will end upon termination of the telehealth connection.
7. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions answered.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Today's Date