**Sunny Meadow Medical Clinic, PC Telehealth Patient Consent**

305 N 37th Street Norfolk, NE 68701-3275 P: 402-370-4100 F: 402-370-4101

I (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to receive this health care service, (type of service) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as a telehealth service. I understand that the health care practitioner (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is located in another location (facility name and address) Sunny Meadow Medical Clinic, 305 N 37 St, Norfolk, NE 68701. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up telehealth services with the health care provider.

I also understand that:

* I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
* I may have to travel to see a health care practitioner in-person if I decline the telehealth service.
* If I decline the telehealth services, the other options/alternatives available for me, including in-person services, are as follows: **see alternative providers in your community**
* The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
* I will have access to all medical information resulting from the telehealth service as provided by law.
* The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.
* I will be informed of all people who will be present at all sites during my telehealth service.
* I may exclude anyone from any site during my telehealth service.
* I may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises OR I will be told ahead of time that this is not available. I have read this document carefully, and my questions have been answered to my satisfaction.
* I also understand that my insurance will be billed for this visit with consulting healthcare provider, (name of provider) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and that I may be billed for what my insurance does not cover, dependent upon the provider. I understand that if I have any questions about my billing, I will need to talk with the provider’s billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.

**I have read this document carefully, and my questions have been answered to my satisfaction.**

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Or

Signature of Parent or Legal Representative:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

If other that patient, relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason (minor, incompetent, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telehealth Consent:**

Signature of Person Obtaining Consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name: Sunny Meadow Medical Clinic, PC

Facility Address: 305 N 37 St, Norfolk, NE 68701

Distribution: The **original form is completed by the provider of the telehealth service and is retained in the patient’s medical record. A copy of the form is given to the patient or patient’s parent/guardian**. Retention: The provider retains the original form in the patient’s medical record