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TELEHEALTH CONSENT FORM

By signing below, it is agreed that _____ will receive medically necessary live, interactive video telehealth services from an Encompass Care provider, who is located at a distant site location.

I, _____, understand that:

- a. I retain the right to refuse telehealth consultations at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
- b. All existing confidentiality protections shall apply to my telehealth consultation.
- c. I shall have access to all medical information resulting from the telehealth consultation, as provided by law.
- d. 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 written consent.
- e. I will be informed whether the telehealth consultation will be or will not be recorded.
- f. I will be informed of all people who will be present at all sites during my telehealth service.
- g. I retain the right to exclude anyone from either the originating or distant site.
- h. Encompass Care will utilize current billing practices for telehealth. If your policy does not cover telehealth services, I understand I am financially responsible for all charges incurred.

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

Signature of Patient/Legal Representative

Date document signed

Encompass Care Representative