CENTER FOR EMOTIONAL HEALTH®

TELEPHONE & VIRTUAL VISIT CONSENT

Patient's Name: (First) _____ (Last) _____

Date of Birth: _____

The below named patient/guardian gives consent for Telephone visits and understands that "telephone" is a non-visual telephone connection between the established patient/guardian and the provider. The patient/guardian understands the risks and benefits of a Telephone visit, including:

1) that provider will do their best to provide reasonable medically necessary determination and treatment based on the patient's/guardian's telephone interview, history, and available test results, and medical records;
2) the limitation of Telephone is that the provider is not providing an in-person live examination, or a Telehealth video examination, by the provider. The patient/guardian understands, acknowledges, and accepts:
    a) Patient/Guardian does not have the ability to conduct a Telehealth visit due to not having a reliable internet access and/or no access to a technology device with which to conduct a telehealth visit (computer, smart phone or tablet).
    b) Theis virtual/telephone visit is intended to take the place of a face-to-face visit.
    c) The covered service being provided is clinically appropriate to be delivered via virtual/telephonic communication and does not require the physical presence of the patient/guardian.
    d) This virtual /telephone visit is a covered benefit.
    e) This virtual/telephone visit is medically necessary.
    f) This covered benefit is clinically appropriate to be delivered via virtual/telephone communication.

The below named patient/guardian also agrees to the following regarding any virtual appointments, including Telephone visits:

1. I understand that I must ensure that the area I choose to conduct my virtual appointment is private, which will allow me to discuss my healthcare concerns without others overhearing.
2. I agree to ensure that the environment is free from distractions. Virtual appointments should not take place while I am driving, running errands, or participating in other activities that could divert my focus from the appointment with my provider.

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____