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. 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. This 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 diver my focus from the appointment with my provider.

X_____ X_____

Name of Patient/Legal Guardian (Please Print) Date

X_____ X_____

Signature of Patient (or Parent/Legal Guardian) Date