Personal Growth Concepts, Inc.
COUNSELING & RELATED SERVICES

Informed Consent for Telehealth Services

Printed Client Name: _____

- I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telehealth visit will be done through a two-way HIPPA compliant audio/video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telehealth.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without effecting my right to future care or treatment.
- I understand that by verbally agreeing and/or signing this form that I am providing informed consent to receive health care services via telehealth.

Verbal Consent Given To: _____
Name Date

Client Signature: _____
Date

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