We value your privacy and protection. Before we start the treatment process, we ask that you kindly fill out the consent form below. Thank you.

I understand that my health care provider will engage in a Tele-health consultation with me. My health care provider has explained to me that consultations and sessions with my provider by video conferencing technology consultations will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.

I understand that a Tele-health consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
I understand there are potential risks to this technology, including interruptions, unauthorized access, or technical difficulties. I understand that my health care provider or I can discontinue the Tele-health consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

CONSENT TO USE THE TELEHEALTH BY CareCloud Live with my Provider
CareCloud Live is the technology service we use to conduct Tele-health videoconferencing appointments. It is simple to use and there are no passwords required to log in. I understand I will receive a link by email or text message, depending on my preference. By signing this document, I acknowledge:

Tele-health by CareCloud Live is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

Though my provider and I may be in direct virtual contact through the Telehealth Service, neither CareCloud Live nor the Tele-health Service itself provides any medical or healthcare services or advice for emergency or urgent medical services.

The Tele-health by CareCloud Live facilitates the videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

I understand that technical difficulties may arise as times that require external technical support to resolve and may require rescheduling of my telehealth visit.

To maintain confidentiality, I will not share my Tele-health appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me and that I fully Understand its content, including the risks and benefits of Telehealth Services;

That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

CONSENT FOR TELEHEALTH CONSULTATION: BY SIGNING ON BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature

DATE

Clear

I understand the concepts and conditions of informed consents, privacy and confidentiality.
I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and treatment/therapy.
When using telemedicine services, technical issues could affect a session if there is a poor connection or non-functioning equipment.
I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information.
I also understand that there are no guarantees of positive outcome for the treatment/therapy.
If I have health insurance, I understand that I am responsible for confirming coverage and network status before I receive treatment and that I am responsible for payment when services are not covered by my plan.
I understand that applicable payment is due at the time-of-service which includes co-pays, balances due on past services according to my health plan coverage, and self-pay service.
I understand that I may ask questions by secure message within the CareCloud portal anytime.
I understand that I am responsible for privacy related to the technologies that I use to connect with my provider and that I must password-protect those technologies to increase the security of my information.
I understand that I may be immediately discharged if my behavior is a threat to my provider(s) or the property of my provider's organization.
Upon such discharge, I understand that I will be given a list of alternate providers in my area from which I may choose a new provider for the continuation of my psychiatric care. I understand I am free to choose another provider that is not on the referral list and that I am responsible for making appointments immediately to prevent gaps in my care.

If you have more questions, please use the contact details below.

[Practice Name] [Practice email] [Practice Phone]

Enter name here

Enter number here

Enter email here

Enter date of birth here