North Central Indiana Medical Clinic LLC Phone (574)832-6246
112 Main Street, Milford IN 46542 Fax: (574)832-2001

Telehealth Consent Form

Purpose: This form is intended to obtain your permission to participate in a telehealth visit.

Introduction: Telehealth is the use of audio, video or electronic communications between you and your healthcare provider. This is not the same as a direct patient/healthcare provider visit due to the fact that you will not be at the same location as your provider. Telehealth provides access to medical care that may otherwise require you to travel. Your participation in any telehealth visit is completely voluntary.

Confidentiality: All existing confidentiality protections under federal and Indiana law apply to information used or disclosed during your telehealth visit.

Medical Information and records: All laws concerning patient access to medical records and copies of medical records apply to telehealth visits.

Risk: In rare instances, security protocols could fail, causing a breach of privacy of personal information. Delays of communication caused by interruption of service connections or quality which may result into a face to face appointment.

Financial Agreement: The telehealth visit will be a billable service to my insurance company or to myself. I understand that any services rendered not covered by my insurance will be my responsibility.

Rights: You may withhold or withdrawal consent to the telehealth service at any time without it affecting your right to future care or treatment.

Patient Consent to The Use of Telehealth

I have read and understand the information provided regarding telehealth services and all of my questions have been answered to my satisfaction. I hear by give my consent.

____ ____________________
Signature of Patient/Guardian Date of Birth

_____________________ ____________________
Date Account #

Created 1/2022