Telehealth Informed Consent

TELEHEALTH PRACTICE PACK

I consent to receiving healthcare through telehealth when clinically appropriate. I understand telehealth uses electronic communications and may have limitations compared with in-person evaluation, including limitations in physical examination, technology failures, and privacy risks.

I understand the clinician may recommend or require in-person or emergency evaluation when telehealth is insufficient.

Patient physical location at visit _____

Callback number _____

Emergency contact _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

Template notice: General educational/operational starting point only. Customize for the actual patient, treatment, product/device, manufacturer instructions, emergency resources, clinician scope, payer requirements, and applicable federal/state law. Obtain qualified clinical and legal review before use.

Asynchronous / Store-and-Forward Care Consent

TELEHEALTH PRACTICE PACK

I consent to asynchronous evaluation using information I submit, which may include questionnaires, photographs, records, device data, or messages. I understand the clinician may determine that synchronous video, telephone, in-person examination, testing, or referral is required before treatment.

Service / condition _____

Information submitted _____

Escalation plan _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Telehealth Patient Location & Emergency Plan

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Patient name / DOB _____

Physical location / address at time of visit _____

Callback number _____

Emergency contact / phone _____

Nearest emergency department / local EMS information if needed _____

Special emergency instructions _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Electronic Communication Consent

TELEHEALTH PRACTICE PACK

- ■ Portal messaging
- ■ Email
- ■ SMS/text messaging
- ■ Voicemail
- ■ Telephone

I understand electronic communications may have privacy and delivery risks and are not appropriate for emergencies. I understand response times should follow the practice's communication policy.

Permitted contact information _____

Restrictions / preferences _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Remote Prescribing Acknowledgment

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I understand prescribing through telehealth is subject to clinical appropriateness, identity/location verification, licensure, controlled-substance requirements, pharmacy rules, and applicable federal and state law. A prescription is not guaranteed solely because I complete a telehealth encounter.

Preferred pharmacy _____

Medication history / controlled medications _____

Required follow-up / monitoring _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Telehealth Technology Failure & Conversion Record

TELEHEALTH PRACTICE PACK

Visit date/time _____

Platform _____

Failure / limitation _____

Identity/location verified _____

Alternative communication used _____

Clinical impact _____

Converted to phone / rescheduled / referred in person _____

Follow-up actions _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Telehealth Visit Readiness Checklist

TELEHEALTH PRACTICE PACK

- ■ Identity verified
- ■ Consent documented
- ■ Emergency contact available
- ■ Technology adequate
- ■ Pharmacy confirmed
- ■ Location verified
- ■ Privacy confirmed
- ■ Medication/allergy list reviewed
- ■ Need for physical exam considered
- ■ Follow-up plan documented

Clinician notes / exceptions _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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