Cruz Clinic Integrative Psychology of Ann Arbor TELEMEDICINE SERVICES CONSENT FORM

| Informed Consent for Telemedicine Services | |
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| •I understand that telemedicine 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 telemedicine visit will be done through will be able to see my image on the screen and hear my voice. provider. | |
| •I understand that the laws that protect privacy and the conficalso apply to telemedicine. | dentiality of medical information including (HIPAA) |
| •I understand that I will be responsible for any copayments or | coinsurances that apply to my telemedicine visit. |
| •I understand that I have the right to withhold or withdraw my my care at any time, without effecting my right to future care | |
| •I understand that by signing this form that I am consenting to | receive health care services via telemedicine. |
| | |
| Signature of Client/Patient | Date |
| Printed Name | _ |
| Phone # | |
| E-mail Address | |
| Witness | Date |
| N: forms/patient forms/telemedicine consent form | |