Cruz Clinic
Integrative Psychology of Ann Arbor
TELEMEDICINE SERVICES CONSENT FORM

Name: _____ DOB: _____

Informed Consent for Telemedicine Services

•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 a two-way 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 (HIPAA) also apply to telemedicine.

•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 consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.

•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 _____