PSYCHIATRIC HEALERS

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Telehealth Consent Form

Health Care Services

By signing this form you agree to the following points:

1. I authorize **Psychiatric Healers** to use appropriate telecommunication technologies for the purposes of evaluating and diagnosing my medical condition and any health complaints.
2. I understand that technical issues may arise before or during telehealth sessions and, on occasion, my appointments may not start or end at agreed-upon times.
3. I accept that medical professionals will attempt to contact me using video conferencing software. However, I also understand that other communication channels, such as telephone calls, may be used in case of internet connectivity or other issues.
4. I understand that my insurance plan may not encompass telehealth services. In cases where my insurance plan does not cover any expenses which have been incurred, I will be personally liable to cover these expenses.
5. I give **Psychiatric Healers** permission to access my medical records for the purposes of ongoing documentation, evaluation, and analysis. I understand that all confidential information will be kept private.

☐ I agree to the terms and conditions listed above.

Name : .....

Signature : ..... Date : .....