TEAMWORK HEALTH
BETTER TOGETHER

Telemedicine Patient Consent Form

Patient Name _____

DOB _____

TeamWork Health PLLC provides Behavioral Health services via telemedicine.

By signing the agreement below, I, the Patient or Patient's Legal Representative, consent to participate in evaluation and treatment recommended by the provider(s) involved in my/the patient's care **via telemedicine.**

- I agree to participate in a telemedicine evaluation and authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other people involved in my medical or mental health care.
- I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other people.
- I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.
- I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.
- I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.
- I understand that some or all of my medical information may be used for teaching or educational purposes.

Signature _____

Date _____

*Please call **(919) 883-1583** if you have questions regarding this policy document.*
*For questions regarding your bill, please e-mail **billing@twhasg.com**.*