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Telehealth Consent Form

Patient:______________________ D.O.B.:__________________

1. I hereby authorize Arctic Skye Family Medicine to use the telehealth practice platform (Doxy.me) for telecommunication for evaluating, testing, and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover. I understand it is my responsibility to check with my insurance provider.

4. I agree that my medical records on telehealth can be kept for further evaluation, analysis, and documentation, and in all of these, my information will be kept private.

I understand these terms and give consent to telehealth treatment.

Patient's Signature: _________________________ Date: _____________

Employee's Signature: _________________________ Date: _____________