



Burrows Family Practice, Inc.

**Telehealth Consent Form**

1. My health care provider wishes me to engage in a telehealth consultation and has explained to me how the video conferencing technology will be used to affect such a consultation and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I have met the following criteria for a telehealth consultation:
  - a. I have an Apple device with Facetime for the consultation
  - b. I have an Android device with WhatsApp Messenger installed on my smart phone for the consultation.
3. I understand there are potential risk to this technology, including interruptions, unauthorized access and technical difficulties. I further understand that my healthcare information may be shared with other individuals for scheduling, billing purposes and video operation, and that I will be informed of their presence. I have the right to request the following: 1) omit specific details of my medical history/physical examination 2) ask non-medical personnel to leave the telehealth exam room and or 3) terminate the consultation at any time.
4. I understand that billing will occur from my practitioner for this telehealth visit. Co-payments will be due and payable before the telehealth consultation. Payments may be made on the [www.BurrowsFamilyPractice.org](http://www.BurrowsFamilyPractice.org) website.

---

Print Patient First and Last Name

---

Date of Birth

---

Patients Signature

---

Date



Burrows Family Practice, Inc.

1377 S. Grand Avenue, Glendora, CA 91740 | Tel: 626.483.3348 | Fax: 626.623.7258 |

Sep 2019