Desire Healthcare LLC
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TELEHEALTH CONSENT FORM

1. I hereby authorize **Desire Healthcare LLC** to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical/Mental health 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 accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. 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.

5. 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.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical/mental health care.

I understand that a copy of this form will be available for me to print.

Patient Printed Name: _____

Patient Signature: _____

Date: _____