TotalWell Health Clinic
1425 Tuskawilla Road Suite 221, Winter Springs, Fl 32708
Phone Number: 407-775-5315
Email: totalwell@gmail.com
Website: www.totalwellhealth.com

CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

I, the undersigned, hereby consent to participate in telehealth services provided by **TotalWell Health Clinic** and its healthcare providers, which may include video calls, online consultations, phone calls, and other forms of virtual care. I understand the following:

WHAT IS TELEHEALTH?

Telehealth involves the use of technology to provide healthcare services remotely. This may include consultations with my healthcare provider via video call, phone call, or other online platforms. Telehealth may be used for various services, including consultations, follow-up visits, management of chronic conditions, and other medical assessments.

CONSENT TO TELEHEALTH SERVICES

1. **Types of Telehealth Services**
   I consent to receiving telehealth services from **TotalWell Health Clinic,** including but not limited to:
   - Video consultations (via video calls using secure platforms)
   - Phone consultations (if video is not available or appropriate)
   - Online messaging or emails (for non-urgent matters and follow-up care)
   - Remote monitoring or data collection (such as blood pressure, heart rate, etc.)
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2. **Confidentiality and Security**
   I understand that **TotalWell Health Clinic** will make every effort to ensure the confidentiality of my health information during telehealth consultations. I understand that these services are

provided using secure, HIPAA-compliant platforms, but I acknowledge that there may be risks involved with using technology for healthcare, including potential breaches in confidentiality.

3. **Technical Requirements**
   I acknowledge that I am responsible for ensuring that I have access to the necessary technology and equipment (such as a computer, smartphone, stable internet connection, and webcam, if needed) to participate in telehealth consultations. I also understand that technical difficulties such as connectivity issues, hardware malfunctions, or other interruptions may occur during a telehealth session.

4. **Limitations of Telehealth**
   I understand that telehealth may not be appropriate for all types of medical conditions, and some issues may require an in-person visit. My healthcare provider will inform me if an in-person consultation is needed. I understand that telehealth services may have limitations in terms of diagnosis, physical examinations, and procedures.

5. **Consent to Treatment via Telehealth**
   I consent to the evaluation, diagnosis, and treatment of my medical condition(s) through telehealth services. I understand that I can ask questions, request clarification, or withdraw consent for telehealth services at any time. I may also request an in-person visit if I prefer.

6. **Emergency Situations**
   I understand that telehealth services are not suitable for emergency situations. In case of an emergency, I will seek immediate care at the nearest emergency department or call 911.

7. **Billing and Insurance**
   I understand that telehealth services may be billed the same as in-person visits, depending on my insurance provider. I will verify my insurance coverage for telehealth services and understand that I am responsible for any costs not covered by my insurance.

RIGHT TO WITHDRAW CONSENT

I understand that my participation in telehealth services is voluntary, and I have the right to withdraw my consent at any time without affecting my right to future care or treatment. If I choose to withdraw consent, I can inform my healthcare provider and request to switch to in-person visits.

ACKNOWLEDGEMENT AND SIGNATURE

By signing below, I acknowledge that I have read and understand the information provided in this **Consent to Participate in Telehealth Services** form. I consent to receiving telehealth services, including the use of video calls, online consultations, and other forms of virtual care, as described above.

- **Patient's Name (Printed)**: _____
- **Patient's Signature**: _____
- **Date**: _____

If applicable (for minors or legal guardians):

- **Legal Guardian's Name (Printed)**: _____
- **Relationship to Patient**: _____
- **Legal Guardian's Signature**: _____
- **Date**: _____

FOR OFFICE USE ONLY

- **Received By**: _____
- **Date**: _____