RHEUMATOLOGY ASSOCIATES, P.A.

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Telehealth Consent Form

- I hereby authorize Rheumatology Associates, P.A. to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
  I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
- 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.
- 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 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 that confidentially will be maintained as described in *Rheumatology Associates, P.A. Notice of Health Information Privacy Practices.*

Patients
Signature:_____DOB:_____

Date:_____