SOAR SERVICES, Inc.

Offices in: Shell Lake, Siren, Hayward, Ashland, Park Falls and Superior

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TELEHEALTH SERVICES CONSENT FORM

Client Name:_____ Date of Birth:_____

- I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when located at a different location or site than I am.
- I understand that the telehealth visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information include (HIPPA) and apply to telehealth.
- I understand that I will be responsible for any copayments or coinsurance that apply to my telehealth visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that if at any time the provider becomes concerned about my well being they will contact 9-1-1 for a welfare check to be conducted.
- I understand that by signing this form that I am consenting to receive healthcare services via telehealth.

Client/Guardian Signature Date

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