TELEHEALTH CONSENT AND AGREEMENT FORM

Provided by Kicotan Acupuncture

Empowering Health Anytime, Anywhere

Welcome to Kicotan Acupuncture

Thank you for choosing [Your Business Name] for your healthcare needs. This document serves as an agreement between you and [Your Business Name] and outlines the terms and conditions of participating in telehealth services. Please read it carefully. Your consent is required to proceed with telehealth consultations.

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1. What Is Telehealth?

Telehealth is the use of secure technology to provide healthcare services remotely. It may include video conferencing, phone consultations, and secure messaging. Telehealth allows healthcare providers to evaluate, diagnose, and treat patients without the need for in-person visits.

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2. Consent for Telehealth Services

By signing this form, you acknowledge and agree that:

1. You understand the nature and purpose of telehealth services.
2. You voluntarily consent to participate in telehealth services with [Your Business Name].
3. You understand that telehealth is not a replacement for in-person care in all situations, and your provider may recommend in-person care if deemed necessary.

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3. Confidentiality and Privacy

- Telehealth services at Kicotan Acupuncture are conducted using HIPAA-compliant technology to protect your personal health information (PHI).
- Your privacy is of utmost importance, and all reasonable measures are taken to ensure secure communication.
- You are responsible for maintaining privacy on your end by choosing a secure and quiet environment for the session.

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4. Risks and Limitations of Telehealth

While telehealth is a convenient and effective way to provide healthcare, it has limitations, including:

- Potential technical disruptions (e.g., poor internet connectivity).
- Inability to conduct certain physical examinations or procedures.
- Telehealth is not suitable for emergencies or life-threatening situations.

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5. Emergency Situations

Telehealth services cannot provide emergency care. In the event of a medical emergency, you must:

- Call 911 or go to the nearest emergency room immediately.
- Notify your telehealth provider as soon as possible about the emergency.

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6. Payment and Insurance Policies

1. **Payment Methods**: Cash, Credit Cards is full payment is due when scheduling your appointment
2. **Insurance**: We currently do not accept insurance.
3. **Cancellation Policy**: Appointments must be canceled or rescheduled at least 24 hours in advance. Late cancellations or no-shows will incur a fee of $20. Your account will be credited towards your next visit.

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7. Patient Right

You have the right to:

- Receive detailed explanations of your diagnosis and treatment options.
- Access your medical records upon request.
- Refuse or withdraw consent for telehealth services without penalty.

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8. Patient Responsibilities

By consenting to telehealth services, you agree to:

- Provide accurate and complete health information.
- Use a stable internet connection and a functional device for sessions.
- Follow your provider's treatment recommendations.
- Refrain from recording telehealth sessions without written permission.

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9. Technology Requirements

To participate in telehealth services, you need:

1. A reliable internet connection.
2. A smartphone, tablet, or computer with a camera and microphone.
3. Access to the telehealth platform used by Kicotan Acupuncture.

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10. Consent to Video or Audio Recording

- Sessions will only be recorded with your prior written consent, if necessary, for training or documentation purposes.
- Unauthorized recording of sessions by patients is prohibited.

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11. State-Specific Terms

Kicotan Acupuncture operates in compliance with all applicable state laws. If you reside in a state with specific telehealth requirements, you will be informed during the consultation process.

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12. Consent to Treatment

By signing below, you confirm that:

- You have read and understood this document.
- You voluntarily consent to telehealth services with Kicotan Acupuncture
- You understand the risks, benefits, and limitations of telehealth.

Patient Information
Full Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Email: _____

Signature: _____
Date: _____

Provider Information

Provider Name: _____
Provider Signature: _____
Date: _____