Choice Family Health Care

Grand Island
217 E Stolley Park Rd., Ste E
Grand Island, NE 68801
Ph: (308) 384-7625
Fax: (308) 384-8904

Kearney
4503 2nd Ave., Ste 209
Kearney, NE 68847
Ph: (308) 234-9140
Fax: (308) 236-5814

Visit us online at www.choicefamilyhealthcare.org

Patient name____ Chart number _____________

Virtual Healthcare Consent Form

1. My health care provider has explained to me how the video conferencing technology will be used. The consultation will not be the same as direct patient/health care provider visits due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
3. I retain the right to refuse virtual healthcare consultations at any time without affecting my right to future care or treatment and without risking the loss of withdrawal of any program benefits to which I would otherwise be entitled.
4. All existing confidentiality protections shall apply to my virtual healthcare consultation.
5. I shall have access to all medical information resulting from the virtual healthcare consultation, as provided by law.
6. If I decline virtual healthcare services, alternative options are available to me. These options are:
   a. Seeing a provider during their in-clinic hours at our clinic.
   b. Referral to an outside agency for in-person services.
7. I will be informed if someone other than the provider is present during my virtual healthcare service.
8. I understand that billing will occur for this visit. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payer.

I understand that this consent is valid for one year for follow-up virtual healthcare services with this health care provider.

I have read this document carefully or had it read to me and my questions have been answered to my satisfaction.

____ _____________________________

Patient signature Date

____ _____________________________

Signature of CFHC staff obtaining consent Date