

Global Telehealth & Psych LLC

Informed Consent

I hereby consent to participate in telehealth services with Global Telehealth & Psych LLC using their website. I understand and agree to the following terms and conditions:

Nature of Telehealth Services: I understand that telehealth involves the use of electronic communications to enable healthcare providers to remotely diagnose, treat, and provide medical advice, including the use of video conferencing, audio communication, and secure messaging.

Potential Benefits and Risks: I understand that telehealth services offer benefits such as increased accessibility to healthcare, convenience, and reduced travel time. However, I acknowledge that there are potential risks, including but not limited to:

Interruptions in communication due to technical failures.

Security breaches despite reasonable efforts to maintain confidentiality.

Limited access to emergency medical services in case of urgent situations.

Privacy and Confidentiality: I understand that my telehealth sessions will be conducted in a private and secure environment. I acknowledge that all interactions between me and the provider will be treated with the same confidentiality as in-person consultations. However, I also understand that there are inherent risks to privacy and confidentiality in electronic communications, and the provider will take reasonable measures to safeguard my information.

Emergency Situations: I understand that telehealth may not be appropriate for emergency medical situations. In case of a medical emergency, I will seek immediate assistance by calling emergency services or visiting the nearest emergency room.

Alternative Care Options: I understand that telehealth services are not suitable for all medical conditions and situations. The provider may recommend alternative

modes of care, including in-person consultations, diagnostic tests, or referrals to specialists.

Financial Responsibility: I understand that telehealth services may be covered by my health insurance plan, but I am responsible for verifying coverage and understanding any associated costs, including copayments, deductibles, or coinsurance. I agree to pay for telehealth services rendered by the provider in accordance with the fee schedule.

Recording and Documentation: I understand that the provider may document and record our telehealth sessions for treatment, quality assurance, or training purposes. I consent to the recording and documentation of these sessions.

Consent by Registration: By registering for telehealth services, I acknowledge that I have read and understood this Informed Consent Form and agree to its terms and conditions. I understand that by registering for telehealth, I have electronically signed this consent form.

I have had the opportunity to ask questions and discuss any concerns regarding telehealth services with the provider. By registering for telehealth, I acknowledge that I have been provided with satisfactory answers and information.