



CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual who is located at a different site than the provider. Telehealth may involve secure electronic transmission of video, photographs, and/or details of my medical record.

I understand the following:

- I have the right to withhold or withdraw my consent to telehealth at any time, without affecting my right to future care or treatment, or to any insurance/program benefits to which I would otherwise be entitled. I may revoke my consent orally by contacting Clínica Tepeyac by phone at 303-458-5302.
- I have the right to request in-person services as an alternative to telehealth. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
- The laws that protect privacy and the confidentiality of medical information apply to any care provided by telehealth. I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location.
- I am responsible for any charges from Tepeyac that are not covered by my insurance, except as prohibited by law, or by agreement between my insurance carrier and Tepeyac. I authorize Tepeyac to file any claims for payment to my insurance. It is my responsibility to know what providers and telehealth services are covered under my insurance plan.
- I am responsible for preparing a confidential space in which to have my telehealth visit. I agree to not make a recording of the visit without my medical provider's permission.

I consent to telehealth care performed by my physician and all other associated health care providers at Clínica Tepeyac (Tepeyac). This includes examinations, diagnostic testing, treatment, behavioral health, dental, and other services deemed appropriate by my provider. By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

Printed Patient Name

Patient or Parent/Legally Authorized Signature

Date

Printed Name & Relationship to Patient