Harmony Community Clinic
1103 W Hibiscus Blvd, Suite 302A, Melbourne, FL 32901 · harmonycommunityclinic@gmail.com

Telehealth Informed Consent

Patient name (print) _____ Date of birth _____ Date _____

What telehealth is

Telehealth means receiving health care services through secure video, phone, or electronic communication instead of an in-person visit. Telehealth visits at Harmony Community Clinic follow Florida law (Section 456.47, Florida Statutes) and the same privacy standards as office visits.

Possible benefits

- Easier access to care without travel or waiting room time.
- Faster follow-up for medication management, test results, and questions.

Possible risks and limitations

- The provider cannot perform a complete physical examination, which could affect the accuracy of the assessment.
- Technical problems (poor connection, poor video or audio) may delay or interrupt the visit.
- Although secure systems are used, there is a small risk that electronic information could be accessed by unauthorized persons.
- The provider may decide that telehealth is not appropriate and ask me to come in person.
- Some medications, including certain controlled substances, may not be prescribed through telehealth under state and federal law.

I agree that:

- I will be physically located in the State of Florida at the time of each telehealth visit, and I will tell the provider my location at the start of the visit.
- I will join from a private place and verify my identity when asked.
- I will not record any visit without the written agreement of the provider, and the clinic will not record visits without my consent.
- Telehealth is not for emergencies. In an emergency I will call 911.
- Telehealth visits are billed as clinical services, and I am responsible for payment according to the Financial Policy.
- I may decline telehealth at any time and request an in-person visit instead.

I consent to receive care through telehealth. _____ Initials

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Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.