

Sixteenth Street Community Clinic Telehealth Patient Consent Form:

I (name): \_\_\_\_\_ agree to receive this health care service, (type of service): \_\_\_\_\_, as a Telehealth service. I understand that the health care practitioner (name) \_\_\_\_\_ is located at **Street Community Health Center** (clinic address): \_\_\_\_\_.

A Telehealth service means that my visit with a practitioner at distant site will happen by using special audiovisual equipment. This consent is valid for six months for follow-up Telehealth services with health care provider.

I also understand that:

- I can decline Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline Telehealth service.
- If I decline the Telehealth services, the other options/alternatives available for me, including in-person services, are as follows: seek alternative providers in your community.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researcher or anyone else without my additional written consent.
- I will be informed of all people who will be present at all sites during my Telehealth Services.
- I may exclude anyone from any site during me Telehealth visit.
- I may see an appropriately trained staff person or employee in-person immediately after the Telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
- I also understand the my insurance will be billed for this visit with consulting health care provider, (name of provider): \_\_\_\_\_ and that I may be billed for what my insurance does not cover, dependent upon the provider. 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 of third-party payor.
- I understand that if I do not have insurance, and am an established patient I can access the Sliding fee services provided by the clinic, and that if I am a new patient I may speak to someone about whether I qualify for sliding fee scale.

- I give permission for the Sixteenth Street Community Health Center to provided limited information to the coordinator at this site for billing purposes.

**I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for six months and will be renewed after\_\_\_\_\_6 Months\_\_\_\_\_.**

**Name of the facility: Sixteenth Street Community Health Centers**  
**Address: 1032 S. Cesar S Chavez Dr. Milwaukee, WI 53204**