**Telehealth Consent Form **

I, [Patient's Full Name], hereby consent to participate in telehealth visits with Pomegranate Health

Purpose of Telehealth Visit:

Telehealth services may be used for evaluation, diagnosis, consultation, treatment planning, and follow-up appointments. These services may include, but are not limited to, videoconferencing, telephone calls, secure messaging, and other forms of electronic communication.

Potential Benefits:

The potential benefits of telehealth services may include increased access to healthcare, the convenience of remote consultations, and the ability to receive medical advice without the need for in-person visits.

Potential Risks:

I understand that there are potential risks associated with telehealth services, including but not limited to technical failures, interruptions in communication, unauthorized access to information, and the limitations of virtual assessments. I acknowledge that telehealth may not be suitable for all medical conditions and that in some cases, an in-person visit may be necessary.

Privacy and Security:

I understand that Pomegranate Health takes measures to ensure the privacy and security of my health information during telehealth visits. However, I acknowledge that no electronic communication is completely secure, and there is a risk of unauthorized access.

Confidentiality:

I understand that the same confidentiality and privacy protections apply to telehealth visits as to in-person visits. The healthcare provider will take reasonable steps to ensure the

confidentiality of all communications, and I am responsible for providing a private and secure location for the telehealth visit.

Informed Consent:

I have had the opportunity to ask questions and have received satisfactory answers regarding the telehealth services. I understand the purpose, benefits, and potential risks associated with telehealth visits. I consent to participate in telehealth visits with [Provider's Full Name] at [Your Organization Name].

Waiver of Liability:

I hereby waive any liability on the part of Pomegranate Health and its healthcare providers for any unforeseen outcomes or consequences related to the use of telehealth services. I understand that telehealth involves certain risks, and I voluntarily assume these risks.

Emergency Contact:

I agree to provide Pomegranate Health with my current emergency contact information, including the name and phone number of a local emergency contact.

Follow-up Care:

I understand that follow-up care may be recommended after a telehealth visit, and I agree to follow the healthcare provider's recommendations.

Termination of Telehealth Services:

I understand that Pomegranate Health reserves the right to terminate telehealth services at any time if it is determined that this mode of communication is not suitable for my healthcare needs.

Ineligibility and Continued Use

I understand that the one time consult fee applies even if I am determined to be not eligible for any programs.

Patient Consent:

I have read and understand the information provided in this consent form, including the waiver of liability. By signing below, I voluntarily consent to participate in telehealth visits with Pomegranate Health.

Patient's Full Name (Print): __________________________

Patient's Signature: _________________________________

Date: __________________________

Parent/Guardian (if applicable): ______________________

Relationship to Patient (if applicable): __________________

Provider's Signature: ________________________________

Date: __________________________