Patient Name: _____

Date of Birth: _____

Telehealth Visit Consent & Acknowledgement

I am choosing to have one or more telehealth visits with my healthcare provider at the Center for Weight Loss Success. I understand and agree to the following:

- Virtual appointments should not take the place of routine physical exams by your primary care provider or other medical provider.
- Virtual appointments can work very well for routine follow-up.
- For an optimal experience, please be sure to be in a quiet environment conducive to your visit (i.e. not driving, minimal distractions)
- I am responsible for this appointment and agree to keep it unless I give 24 hour notice of cancellation or modification of day/time.
- Virtual appointment connections with my healthcare provider will be done as close to my appointment time as possible.
- Just as an office appointment, if my insurance company does not cover the cost of this appointment, I will be responsible for the bill.
- I permit the Center for Weight Loss Success to keep my credit card on file and to use such credit card for my insurance co-pays and deductible amounts.

_____ _____

Patient Signature Date

_____

Patient Printed Name