Glow Health
MEDICAL CLINIC

Telehealth Consent Form

1. I authorize Glow Health Medical Clinic to use appropriate HIPAA compliant telecommunications technologies for the purpose of evaluating and diagnosing my medical condition and any health complaints.
2. I understand the technical issues may arise before or during telehealth sessions and, on occasion, my appointments may not start or end of the agreed upon times.
3. I accept that medical professionals will attempt to contact me using video conferencing software. However, I also understand that other communication channels, such as telephone calls, may be used in case of Internet connectivity or other issues.
4. I give Glow Health Medical Clinic permission to access my medical records for the purpose of ongoing documentation, evaluation, and analysis. I understand that all confidential formation will be kept private.
5. I understand that payment in full is required at time of scheduling service.
6. Refunds will be given if the appointment is canceled and not rescheduled.

Printed Name: _____

Signature: _____Date: _____