Milestone Wellness LLC

370 A Main Street Laurel, Maryland 20707

Phone:240-755-1056, Fax:844-205-8454

TELEHEAL PATIENT CONSENT FORM

I (Name)_____ agree to receive this health care service.

_____ as a Telehealth service I understand that **Milestone Wellness, LLC behavioral** health service is located in 370 Main Street Laurel, Maryland 20707.

A Telehealth service means that my visit with a practitioner at the distance site will happen by using special audiovisual, consent is valid for one year, and for follow- up Telehealth services with the health care provider. I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and benefits to which I would otherwise be entitled cannot be taken away.
- I may have to see the care practitioner in- person if I decline the Telehealth service.
- 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 researchers 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 service.
- I may exclude anyone from any site during my Telehealth service.
- 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 that my insurance will be billed for this visit with consulting with **Milestone Wellness, LLC behavioral health care services.** _____, and that I may be billed for what my insurance does not cover. 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 or third-party payor.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for one year.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature if other than patient, relationship to patient Reason (minor) Date

_____ _____

Witness Date

_____ _____

Signature of Person Obtaining Consent Date