Telehealth informed consent

Please read this form before your first video appointment. Ask your clinician about anything you would like explained before you sign.

1. Your practice and clinician

Practice name

Date

Clinician name

License number

Practice address

Practice phone

States where clinician is authorized to practice

Telehealth platform

Allia

2. Your details and location

Client full name

Date of birth

Phone number for this appointment

Email

Your physical location during the appointment (full address, including state)

Tell your clinician where you are at the start of each appointment and before joining from another state. Your clinician must be licensed or otherwise authorized to provide care where you are located.

3. Emergency contact and connection plan

Emergency contact name

Relationship

Emergency contact phone

Nearest emergency department (if known)

If the connection drops, our plan is (practice completes)

Telehealth is not an emergency service. For immediate danger or a medical emergency, call 911 or go to the nearest emergency department.

4. How telehealth works

Telehealth lets you meet with your clinician by video without traveling to the office. Connection problems, interrupted sound or video, and privacy risks may affect a visit. Some concerns need an in-person assessment. Your clinician will discuss another option if telehealth is not suitable.

Allia uses an encrypted connection. Join from a private space where others cannot overhear you. Technology alone cannot guarantee privacy.

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5. Privacy, recording and your choices

This form does not give permission to record or transcribe appointments. Your clinician will explain either and ask for separate consent. Under this practice policy, recording, photos and screenshots need written permission from everyone taking part.

Telehealth is your choice. You may withdraw consent or ask about in-person care. Your clinician will discuss available options and scheduling. You can ask who is treating you, request access or changes to your records, and raise privacy concerns with the practice.

6. Fees and insurance (practice completes)

Telehealth appointment fee

CPT code (if applicable)

In-person appointment fee (if applicable)

Copay, coinsurance or deductible

Insurance plan (if applicable)

Member ID (if applicable)

Late cancellation / no-show fee (if applicable)

Notice required

Coverage and cost sharing vary by plan. Your share of costs depends on your plan, the practice's financial policy, payer agreements and applicable law. Ask the practice about charges before your appointment.

7. Your acknowledgment and consent

- [ ] I have read this form and had my questions answered.
- [ ] I understand the benefits, limitations and privacy risks of telehealth.
- [ ] I understand telehealth is voluntary and I may withdraw my consent.
- [ ] I will tell my clinician my physical location at the start of each appointment.
- [ ] I understand recording and AI transcription require separate consent.
- [ ] I have reviewed the fee information and know who to ask about my costs.
- [ ] I consent to receive care by telehealth from the clinician and practice named in this form.

8. Signatures

Client signature (type full name)

Date

Representative signature, if applicable (type name)

Relationship / authority

Date

Clinician signature (type full name)

Date