THE CENTER FOR MEDICAL HEALING
ANNETTE DA SILVA, DO. FAAPMR, FAOCPMR

Telehealth Consent Form

Health Care Services

---

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing, and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

☐ **I agree to the above conditions**

Name:

Date:

Signature:

161 Madison Avenue • Suite 11E • New York, NY 10016
206 Bergen Ave. • Suite 203 • Kearny, NJ 07032 • 201-997-0970
292 Bloomfield Ave • Montclair, NJ• 201-681-1800
Toll Free Phone/Fax: 888-485-0001 • www.thecenterformedicalhealing.com