THE WINSTON CLINIC, P.A.

P.O. BOX 100
SHERIDAN, AR 72150
PHONE (870)942-3000 FAX (870)942-3005

CONSENT FOR TELEHEALTH SERVICES

1. I understand that my health care provider wishes to engage in a telehealth visit or series of visits. I understand that these encounters will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider. Instead, we will communicate using two-way simultaneous audio-visual technology ("the technology").
2. I understand that I have the right to refuse to participate in any telehealth encounter at any time or to end it at any point during the encounter. I understand that if I do not wish to participate in a telehealth encounter I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care. I further understand that my provider may not be able to accommodate an in-person visit and there may be a delay in my care if I choose an in-person visit.
3. I understand that my health care provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care.
4. I understand how the technology will be used to conduct any telehealth encounters with this practice. I also understand that, with this technology, there is a risk of interruption and technical difficulties.
5. I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.
6. I understand that I will be told the identity of everybody who will be in the room with my healthcare provider during any telehealth encounter and that those people will be present only because my health care provider has determined that their presence is necessary to assist in my medical treatment according to the applicable standard of medical care.
7. I have been told whether my provider is licensed to provide medical care in the state where I am located. If they are not licensed in the state where I am located, I consent to receive telehealth services anyway because the provider is fully licensed in the state where they are located.
8. I understand that I will be responsible for any copays and coinsurance that apply to my telehealth encounter (s). On the day of my appointment I understand my co-pay will be deducted from my card on file. If I have a deductible plan, I understand my visit total will be deducted after my appointment. I understand I will receive a call from The Winston Clinic with the total amount that was deducted. If I do not answer I understand my receipt will be mailed to me.
9. This consent will remain valid for six (6) months from the date of my first telehealth visit.

_____	_____	_____
PRINT NAME	DOB	DATE

_____	_____
SIGNATURE	EXPIRATION DATE

Scott D. Winston, M.D.
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Brittney D. Hensley, APRN
Joshua A. Garner, APRN
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