TELEHEALTH INFORMED CONSENT FORM
Nova MFM – Washington State

Effective Date: 4/1/2026

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1. Introduction

Telehealth involves the use of electronic communications (such as video, audio, and secure messaging) to provide healthcare services remotely. This form explains your rights, risks, and responsibilities when receiving telehealth services from Nova MFM.

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2. Nature of Telehealth Services

By signing this form, you understand that:

- Telehealth may include consultations, diagnosis, treatment, follow-up care, and patient education
- Your provider may not be physically present in the same location as you
- Technology will be used to communicate and share your health information

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3. Privacy and Security

- We use secure, HIPAA-compliant systems to protect your information
- Your medical information will be handled according to our Notice of Privacy Practices
- There are potential risks to privacy due to the use of technology, including unauthorized access
- Telehealth sessions will not be recorded without your written consent

You are responsible for:

- Choosing a private location for your visit
- Protecting your device and login credentials

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4. Risks of Telehealth

Potential risks include:

- Technical issues (e.g., poor internet connection, interruptions)
- Delays in care due to technology failure
- Limited ability to perform physical examinations
- Rare risk of unauthorized access to your information

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5. Benefits of Telehealth

- Convenient access to care without travel
- Timely medical consultations
- Increased continuity of care

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6. Alternatives to Telehealth

You have the right to choose in-person care instead of telehealth at any time, where available.

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7. Consent to Treatment

By signing below, you:

- Consent to receive healthcare services via telehealth
- Understand the risks, benefits, and alternatives
- Authorize Nova MFM to use and disclose your information for telehealth purposes
- Understand that you may withdraw consent at any time by notifying the clinic

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8. Patient Acknowledgment

I have read (or had explained to me) this Telehealth Consent Form. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

If signed by personal representative:

Name of Representative: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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9. Provider Statement (Optional)

I have explained the telehealth process, including risks, benefits, and alternatives, to the patient (or their representative).

Provider Name: _____

Provider Signature: _____

Date: _____
