

1. I hereby authorise Western Family Practice 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 a Telehealth visit will NOT cost any more than a clinic visit (providing I have a current Medicare card)
5. I agree that my medical consultation during telehealth will be documented in the practice medical software and can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

Full name: _____

Signature: _____ Date: _____

