MY MED VALET

TELEHEALTH ONLINE REGISTATION

Follow these 3 easy steps to book your appointment

1

Fill out the following the form

2

Email your completed form to mymedvalet@gmail.com

3

Our office will be with you shortly!

MY MED VALET: TELEHEALTH INFORMATION

PERSONAL INFORMATION:

First and Last Name: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female** ☐ **Other** _____

CONTACT INFORMATION:

Phone Number: _____

Email Address: _____

Desired Method of Contact:

☐ **Phone** ☐ **Video Call**

EMERGENCY CONTACT:

First and Last Name: _____

Relationship: _____

Phone Number: _____

INSURANCE INFORMATION:

Subscriber Name:_____

Member Number:_____

Group Number:_____

ADDRESS:

Street Address: _____

Street Address Line 2: _____

City: _____ **State/ Province:** _____

Postal/Zip Code: _____

REFERRALS AND ADJUNCTIVE CARE:

Are you currently under medical care? ☐ **Yes** ☐ **No**

If yes, what are you currently under medical care for?

Primary Care Physician:

First Name:_____ **Last Name:** _____

Practice Name: _____

HEALTH CONCERNS:

Please explain your health concerns or symptoms:

When did the issue, symptoms, or illness start?

Date: _____

COMMUNICATION PLATFORM:

Which Platform will you be using for our Telehealth services?

☐ **Zoom** ☐ **Updox** ☐ **Facetime (Apple)**

Consent to Participate in Telehealth

1. Service

The healthcare facility will need to collect and record the patient's personal and medical information. During the telehealth visit, the patient will be contacted via videoconference software.

If the videoconference cannot be held during the appointment time, the patient will be called via phone which is stated in the form.

2. Software

Telehealth visits are held by using different software in order to increase the productivity and effectiveness of the visits. All information is password-protected.

3. Confidentiality

All the medical or personal information of the patient will be kept private. The medical condition of the patient will be used for further researches anonymously.

4. Rights

The patient can withdraw or withhold the consent at any time and it will not affect the further treatment.

The patient can end the videoconference with the healthcare consultant, physician, or professional at any time.

Signature and Submission

I have informed about the telehealth practices and I have been given the opportunity to ask questions about services, consultation, and practice. I have acknowledged that the information I have given in the form is accurate and complete. I have understood and given my consent to participate in telehealth services.

☐ **I Agree to the Terms and Conditions**

Patient Name:

_____ _____

First Name Last Name

Signed By (if signed by person other than the patient):

_____ _____

First Name Last Name

Relationship to Patient (if signed by person other than the patient):

_____

Relationship

Date: _____

Signature: