

General & Telehealth Consent Form

Prime Virtual HealthCare & Wellness (PVHCW)

Patient Name: _____

Date of Birth: _____

Date: _____

1. General Consent for Treatment

I authorize **PVHCW** providers to evaluate, diagnose, and treat me, including ordering labs, prescribing medications, and providing counseling or referrals.

2. Telehealth Services

I consent to the use of telehealth for evaluation and treatment. I understand the risks (technical failures, limited exam) and benefits (convenience, continuity of care).

3. Patient Rights

I may refuse or withdraw consent at any time. I can ask questions and request copies of my records.

4. Confidentiality

My information will be kept confidential under HIPAA. Electronic transmission may carry some privacy risks despite security measures.

5. Emergency Disclaimer

I understand PVHCW does not provide emergency services. If I have an emergency, I will call 911 or go to the nearest ER.

Patient Electronic Signature: _____

Date: _____

Provider Signature: _____

Date: _____