DHCS Telehealth Policy Implementation

Patient Consent –Model Language

Written Consent Communication

1. I agree to receive health care services via telehealth. I understand that:
    a. I have the right to access Medi-Cal covered services through an in-person, face- to-face visit or through telehealth.
    b. The use of telehealth is voluntary, and I may withdraw my consent to, or stop receiving services through telehealth at any time without affecting my ability to access covered services in the future.
    c. Medi-Cal provides coverage for transportation services to in-person services when other resources have been reasonably exhausted.
    d. There may be limitations or risks related to receiving services through telehealth as compared to an in-person visit. For example_____.
2. I have read this document carefully, understand the potential limitations and risks of receiving services via telehealth, and have had my questions answered to my satisfaction.

Verbal Consent Communication

"Under Medi-Cal you have the option to receive services in person in a face-to-face visit or via telehealth. If you have trouble accessing in person services due to transportation, Medi-Cal provides coverage for transportation services when other resources have been reasonably exhausted. There may be limitations or risks related to receiving services through telehealth rather than in person. For example_. If you choose to receive services by telehealth, you may change your mind at any time by letting us know. If you change your mind about using telehealth, you will still have access to Medi-Cal covered services.
Knowing all of this, do you want to have the option of receiving services from us now or in the future via telehealth? (Yes/No)."

_____ _____
PRINT NAME DATE

_____ _____
SIGNATURE DATE OF BIRTH