



VIRTUAL MEETING CONSENT FORM

Client Name: _____ **Date:** _____

Medical Chart Number: _____ **Date of Birth:** _____

I, _____ (Client Name), request to participate in a virtual meeting/consultation with Palm Beach Women’s Clinic personnel.

I understand that the virtual meeting is a virtual/video teleconferencing consultation, provided to me as a convenience, and at my request. I further understand that I can withdraw my consent verbally or in writing for this time of meeting at any time and the clinic personnel will schedule an appointment in the live clinic.

I understand that Palm Beach Women’s Clinic will only offer virtual consultations during this time to clients residing in the state of Florida and that I am responsible to notify the clinic personnel if I am out of state or move out of state.

I understand that this virtual consultation is with unlicensed and licensed personnel and not a substitute for therapy and /or any other kind of healthcare.

I understand that virtual consultations will not be conducted while I am operating a motor vehicle.

I understand that the video conferencing service used by the clinic is HIPAA compliant. I further understand that this is a risk inherent in online communication and will not hold Palm Beach Women’s Clinic liable for any breach of confidentiality resulting from the digital platform used for the meeting.

Signature of Client

Date