Chronic Pain Telehealth Consent Form

Patient Information

Full Name

Date of Birth

Phone Number

Email Address

Telehealth Services

Consent and Acknowledgement

- ☐ I understand the purpose and nature of telehealth consultations for chronic pain management.
- ☐ I understand the risks and benefits associated with telehealth services.
- ☐ I understand I may withdraw consent at any time.
- ☐ I am responsible for providing accurate information during telehealth sessions.
- ☐ I acknowledge all my questions have been answered regarding telehealth.

Signature

Signature (Type your full name)

Date