

1. TELEHEALTH INFORMED CONSENT

(Florida – Medication Therapy Management Services)

Patient Name: _____

Date of Birth: _____

Date of Consent: _____

Telehealth Services

I understand that Medication Therapy Management (“MTM”) services may be provided to me **via telehealth**, including telephone, video conferencing, secure messaging, or other electronic communication technologies.

Telehealth services may be used in place of, or in addition to, in-person services.

Nature of Telehealth

I understand that telehealth:

- Involves communication of my health information electronically
- May include review of medications, education, and recommendations
- Is limited by the quality of the information I provide and the technology used

I understand that telehealth **does not include emergency or urgent medical care.**

Risks and Limitations

I acknowledge and understand that telehealth services involve certain risks, including but not limited to:

- Technical failures or interruptions
- Unauthorized access despite reasonable security measures
- Limitations due to lack of physical examination

I understand that these risks are inherent to telehealth and accept them.

Emergency Care Acknowledgment

I understand that telehealth is **not appropriate for medical emergencies**.

If I experience a medical emergency, I will call **911** or seek immediate in-person medical care.

Privacy and Confidentiality

I understand that my Protected Health Information (“PHI”) will be handled in compliance with **HIPAA** and applicable Florida privacy laws.

I also understand that electronic communications may carry a risk of unauthorized access despite reasonable safeguards.

Voluntary Participation and Right to Withdraw

I understand that:

- Participation in telehealth is voluntary
 - I may withdraw my consent at any time by notifying the Pharmacist in writing
 - Withdrawal of consent will not affect prior services already provided
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Consent

By signing below, I acknowledge that:

- I have read and understand this Telehealth Informed Consent
- My questions have been answered to my satisfaction
- I voluntarily consent to receive MTM services via telehealth

Patient Signature: _____

Date: _____

If signed by a Personal Representative:

Name: _____

Relationship: _____

Signature: _____

Date: _____

2. MTM PATIENT CONSENT AND ACKNOWLEDGMENT

(Medication Therapy Management Services – Florida)

Patient Name: _____

Date of Birth: _____

Date of Consent: _____

Description of MTM Services

I understand that Medication Therapy Management (“MTM”) services are **medication-focused clinical support services** provided by a pharmacist licensed in the State of Florida.

MTM services may include:

- Medication reviews and reconciliation
 - Identification of medication-related problems
 - Education regarding prescription and non-prescription medications
 - Recommendations to improve medication safety, effectiveness, or adherence
 - Communication with prescribers regarding medication-related concerns
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Scope and Limitations

I understand and acknowledge that the Pharmacist:

- Does **not diagnose medical conditions**
- Does **not prescribe, discontinue, or change medications**
- Does **not provide emergency or urgent care**
- Does **not replace my physician or other licensed prescriber**

All treatment and prescribing decisions remain the responsibility of my healthcare providers.

No Guarantee of Outcomes

I understand that:

- MTM services are advisory in nature
 - No guarantees are made regarding clinical outcomes, symptom improvement, or medication effectiveness
 - My prescriber may choose whether or not to act on MTM recommendations
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Patient Responsibilities

I agree to:

- Provide complete, accurate, and current information about my health and medications
- Disclose all prescription drugs, OTC products, supplements, and allergies
- Notify the Pharmacist of changes to my medications or health status
- Follow up with my prescriber regarding MTM recommendations

I understand that inaccurate or incomplete information may affect the quality of services provided.

Privacy and HIPAA Acknowledgment

I acknowledge that my Protected Health Information (“PHI”) will be used and disclosed in accordance with **HIPAA** and applicable Florida law.

I understand I may review the Privacy Policy upon request or on the website.

Financial Responsibility (If Applicable)

I understand that I am financially responsible for MTM services not covered by insurance, if applicable, and that insurance coverage or reimbursement is not guaranteed.

Consent and Acknowledgment

By signing below, I acknowledge that:

- I have read and understand this MTM Patient Consent and Acknowledgment
- I have had the opportunity to ask questions
- I voluntarily consent to receive MTM services

Patient Signature: _____

Date: _____

If signed by a Personal Representative:

Name: _____

Relationship: _____

Signature: _____

Date: _____
