



Consent for Participation in a Group Medical Visit over Zoom

How did you hear about this group? _____

Group Medical Visits are shared medical appointments. Each person's participation is strictly voluntary.

I _____ hereby consent to participating in Group Medical Visits at West County Health Centers.

I understand that (please initial each line):

___ I understand that this is a virtual group, which I am participating in either over Zoom Video or Zoom Phone Call.

___ I will be in a group with a medical care provider and other patients with similar concerns.

___ It is my right to withhold personal information that I do not wish to share with the group.

___ It is my responsibility to respect the privacy of others in the group. I will not share their personal information with anybody else.

___ I understand that only patients of West County Health Centers can participate in group medical visits with The Wellness Center and I will not share the Zoom information with anyone else.

___ I will join the group from a private area, where no family members, friends, roommates, strangers walking by, etc. are able to listen in or see other group participants on my phone or computer screen in order to protect other's privacy.

___ I may to speak to my medical care provider one on one if I have additional personal needs that I would like to discuss privately by remaining on the call after the group has ended or by scheduling a follow up appointment.

___ I can withdraw from the group visit at any time for any reason.

___ Not participating will **not** affect my relationship with my provider, or my ability to receive service with West County Health Centers.

___ Disruptive behavior of any kind will result in the group facilitator or medical care provider asking me to leave the group.

A Group Medical Visit is a form of a medical appointment. Insurance is billed for a limited visit. Co pays and money owed after insurance is billed for Group Medical Visits are both waived during the Shelter in Place order.

My signature confirms that I clearly understand the activities that occur in a Group Medical Visit over Zoom, and that I am willing to participate.

Name (please print): _____ DOB: ___/___/___

Signature: _____ Date: ___/___/___