Informed Consent for Telehealth Services

BY SIGNING THIS DOCUMENT, I AGREE THAT:

- I have reviewed the WHC Telehealth Consent Disclosures.
- I understand the information in the WHC Telehealth Consent Disclosures.
- I agreed to receive mental health services from Wellness Healthcare Clinics through telehealth.

_________________________________ _________________

NAME (PLEASE PRINT) **DATE**

__________________________________ _________________

SIGNATURE **DATE**

4660 Martin Luther King Jr. Ave SW A2 Washington, DC 20032