Telehealth Consent Form

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may decide whether to undergo the procedure after knowing the risks and hazards involved. By utilizing the Practice's telemedicine services you agree:

- Telemedicine involves the use of electronic communications. Electronic systems used will include measures to safeguard your information.
- Our providers may use the information you provide for purposes of diagnosis, recommending therapy or treatment follow-up and/or education. The information you may be asked to provide may include any of the following:
    - Patient medical records
    - Medical images
    - Live two-way audio and video
    - Output data from medical devices and sound and video files.
- Cost: You will be responsible for any copayment, coinsurance, deductible or other out of pocket cost as determined by your insurance carrier and such may be charged by the practice before or after the telemedicine visit. If you are not covered by insurance, you will be responsible for the billed charges for the telemedicine service.
- Potential Benefits: The potential benefits of this service may include, without guarantee, improved access to medical care by enabling a patient to remain in his/her location.
- Potential Risks: As with any medical procedure, there are potential risks associated with the use of telemedicine. While the likelihood may be low, these risks may include, without limitation, the following:
    - The inability to have direct, physical contact with the patient may impact the quality of service.
    - The quality of transmitted data may affect the quality of services.
    - Certain limitations of telehealth services may require you to have an office visit.
    - Delays in medical evaluation or treatment may occur due to deficiencies or failures of the equipment which may include poor video and data quality.
    - Security protocols could fail, causing a breach of privacy of personal medical information.
    - Lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other negative outcomes.

You hereby further acknowledge and agree to the following:

- I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment.
- The laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- Telemedicine is one of the variety of modalities for the provision of medical care that may be available to me.
- I may refuse to participate in a telemedicine interaction and ask my provider about alternative methods of care.
- If my provider believes I would be better served by another form of service (e.g. in person), I may need to make an in-office appointment for appropriate care.

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- In the event of an advance reaction to treatment or an inability to communicate as a result of a technical or equipment failure, I understand I may need to seek follow-up care or assistance at the recommendation of my provider.
- I understand that no warranty or guarantee has been made to me with regards to any results or cure.
- I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.
- I have read and understand the information provided above regarding telemedicine and hereby authorize my provider and its employees, agents and independent contractors, to use telemedicine in the course of my diagnosis and treatment.

BY ENGAGING IN THIS TELEMEDICINE SESSION YOU AGREE AND CERTIFY THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED ABOVE, AND UNDERSTAND THE RISKS AND BENEFITS OF TELEMEDICINE. BY ACCEPTING THESE TERMS YOU HEREBY GIVE YOUR INFORMED CONSENT TO PARTICIPATE IN A TELEMEDICINE VISIT AND FOR THE USE OF TELEMEDICINE IN YOUR MEDICAL CARE.

By electing to proceed, you agree that all of your questions about telehealth visits have been answered to your satisfaction and consent to telehealth visits.

Patient name: _____

Patient location: _____

Date: _____

Patient verbally consented to telemedicine appointments or messaging with interactive video and/or audio: ____

[Check or signify yes or no]

Provider name: _____

Provider location: _____

Form Completed by: _____

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