

## Telemedicine Consent Form

Patient Name \_\_\_\_\_

Patient DOB \_\_\_\_\_

If the patient is a minor, please complete the following

Parent/Guardian Name \_\_\_\_\_

### Introduction

Telehealth involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this form is to obtain your consent to participate in a Telehealth consultation for various medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.

### Confidentiality

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth consultation.

### Nature of Telehealth Consent

During the Telehealth consultation: Details of your medical history, examinations and tests will be discussed using interactive video and/or audio, A virtual examination may take place, Other medical professionals such as Medical Assistants and/or Scribes may be present during the visit to assist the provider and Photographs may be taken of you during the service In an emergency, it is the responsibility of the Telehealth provider to direct the patient to emergency medical services, such as an emergency room. The Telehealth provider may also discuss and advise with the patients local provider (if applicable). The Telehealth providers responsibility will end upon the termination of the Telehealth connection.

### Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation.

### Your Rights

You may withhold or withdraw consent to the Telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

### Billing and Payment

This demo practice participates with many, but not all insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. It is also your responsibility to provide accurate insurance information prior to the service. If you do not have your up to date insurance information, we will reschedule your appointment or classify your appointment as self-pay. Telehealth services may not be covered by all insurance plans. If your insurance does not cover the Telehealth visit, you will be considered self-pay and our published self-pay fee will apply. Non-covered Telehealth visits will be the patients responsibility.

I Consent to Telehealth

By checking the above box, you are verifying you've read, understand and agree to all conditions indicated on the consent.

Date of consent \*