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Telemedicine Consent Form

Patient Name: _____ DOB: _____

Names of any Persons involved during the telemedicine visit: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used. I am aware that this type of consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that a telemedicine consult is not intended to replace a full medical face-to-face evaluation by a provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate or assist with the technology associated with the visit. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
   (1) omit specific details of my medical history/physical examination that are personally sensitive to me
   (2) ask non-medical personnel to leave the telemedicine examination room: and or
   (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me and have made the choice to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider. I assume the risk of the limitations set forth herein, and I further understand that no warranty or guarantee has been made to me concerning any particular result related to my condition or diagnosis.
6. I understand that billing to my insurance company will be done as a telemedicine visit and as such, I may be financially responsible for full or partial payment of any non-covered or partially covered service. I realize that it is my responsibility to contact my individual insurance carrier to ensure that telemedicine services are covered.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- I have given consent of my own free will (or by a parent or guardian)
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____
Patient's/parent/guardian signature	Date	Time
_____	_____	_____
Witness signature	Date	Time