

## Sunstate Medical Clinic

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### Consent for Non-Face-to-face "Virtual" Visits

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Time: \_\_\_\_\_ am / pm

I, \_\_\_\_\_ hereby voluntarily consent to receive "virtual" care.

Examples of the virtual services offered here are:

**Virtual check-ins** – You and your treating provider may have a brief phone call to determine whether or not an in-person visit or other appropriate treatment is needed.

**E-visits** – You may communicate with your treating provider through our patient portal or secure email.

**Telehealth visits:** You and your treating provider can use real-time interactive audio and video communication that permits real-time communication – like Doxy.me, FaceTime, Skype , What's App – to conduct a visit while you are home.

I understand that this consent form will be valid and remain in effect as long as I receive medical care at Sunstate Medical Clinic.

"Virtual Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider. \_\_\_\_\_ (initials)
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording. \_\_\_\_\_ (initials)
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. \_\_\_\_\_ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care. \_\_\_\_\_ (initials)
- I understand that standard deductible and coinsurance amounts apply to these "Virtual Visits" and I consent to Virtual Treatment \_\_\_\_\_ (initials)
- I understand that I have called and confirmed with my insurance that the above services are covered. If the services are denied by my insurance I am liable for the Physicians fees of \$50 (FIFTY) per session \_\_\_\_\_ initials

This form has been explained to me and I fully understand this *Consent for Non-Face-to-face "Virtual" Visits* and agree to its contents.

**Signature of Patient or Person Authorized to consent for patient:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

☐ Above explained to the patient and verbal consent was obtained

\_\_\_\_\_  
Date