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TELEMEDICINE CONSENT

Introduction: Please read this document thoroughly and completely. Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

Consent for Treatment: You have voluntarily requested that a health care provider of South Texas Healthcare Inc. participate in your medical care using Telemedicine. In doing so, I _____ understand, acknowledge, and agree to the following:

I.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. The healthcare provider providing the Telemedicine services must rely on the information you provide.
4. To the best of my ability, I agree to provide complete and accurate information concerning my medical history, condition and care as may be requested by the health care provider.
5. I understand that if the healthcare provider feels that my medical needs cannot be adequately addressed using Telemedicine, I may be required to seek an in-person evaluation.
6. I understand that no guarantee of any specific result or cure is made by the healthcare provider rendering the Telemedicine services.
7. I understand that the advice provided by the healthcare providers may be based on factors not within his/her control, such as incomplete or inaccurate information provided by me or distortions of diagnostic images or specimens due to their electronic transmission.
8. If I experience an emergency after the Telemedicine session, I should alert my primary treating physician and dial 911 or go to the nearest emergency department.
9. I understand that there are potential risks to using technology, including service interruptions, interception, electronic tampering, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
10. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting South Texas Healthcare Inc. at (210) 491-1690.
11. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
12. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
13. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ Patient/Guardian Printed Name

_____ Patient/ Guardian Signature and date