**Desert Sky Endocrinology**

**Office of Dr. Vidhya Kannan & Kalynn Borer PA-C**

8427 E. Baseline Rd. Ste 104, Mesa AZ 85209

Phone: (480) 832-0900 Fax: (480) 832-3005

**Please email this signed consent back to** [**kannan@desertskyendo.com**](mailto:kannan@desertskyendo.com) **or mail to : 8427 E Baseline Rd Ste 104 Mesa AZ 85209. We will call you once this has been received.**

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

Medical Record No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Internal use only

1. I understand that my health care provider wishes me to engage in a telemedicine consultation. I understand that telemedicine will be used only when a state of emergency has been issued.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a 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.

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 the video equipment.  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 in choosing 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.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist’s responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee. Copays and deductibles will still be required.

8. Commercial insurance patients: I understand that in the event my insurance company does not pay for this service I will be responsible for fee for service in the amount of $60.00 per each date of service.

9. I will have a direct conversation with my doctor, during which I will have the opportunity to ask questions regarding 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.

10. I understand that it is my responsibility to ensure that my surroundings during my telemedicine visit are in a private and quiet environment.

**By signing this form, I certify:**

• That I have read or had this form read and/or had this form explained to me

• 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.

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(Print Name) (Signature) (Date)