Telemedicine Consent Form

What is telemedicine:
Telemedicine is the use of electronic information and communications technologies to provide and support health care when distance separates the participants.

Telemedicine Visit Guidelines:

- The patient must be in a secure location (home, private work space, clinic, hospital or other patient care facility) during the time of visit.
  * * * It is not recommended to participate in a telemedicine visits in non-secure locations, such a public spaces and/or your vehicle.
- Services must be rendered via our real-time video capable portal, which can be accessed via AthenaPatient mobile application or on our website.
- An in person visit is required to have been performed within the last year in order to be eligible for telemedicine services.

Possible Risks:
There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
- Technology problems may delay medical evaluation and treatment for the encounter. This may result in a required in-person visit.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified if any security issues arise.

By Signing this Form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
5. I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. This includes financial responsibility for the visit, in full, if telemedicine is not a covered service with the payor(s) on file with the practice. Determination of covered services is each patient's responsibility to be aware of what their insurance plan allows. Non-covered services will be the patient's responsibility.
6. I understand that if I do not follow the telemedicine visit guidelines, outlines in paragraph two of this consent form, that my insurance carrier may not pay for my visit.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I also consent to photographs of this video encounter being taken and stored in my patient file.

_____ _____

Patient Name (Please Print) Date

_____

Patient Signature