Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider, and hereby consent to give Dr. Robert S Dalton providing healthcare services to me via telemedicine.

I understand that the law protects privacy and confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or 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. I man revoke my consent orally or in writing at any time by contacting Dr. Robert Dalton at Dalton Chiropractic Office. As long as the consent is in force (has not been revoked) Dr. Robert Dalton may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of patient (or person authorized to sign for the patient)

Signature ____ Date: ___________________

If authorized signer,
Relationship to patient ____________________________ Date: ___________________

Witness ____ Date: ___________________

I have been offered a copy of this consent form (patient initials) _________

Completed by Provider:
Provider Name _______________________________________
Patient Name ____ DOB ________________
Patient Location _____________________________________
How Consent from patient obtained:
Verbally ______ Date Discussed _______________
Online ______
Paper ______