**Telemedicine Consent Form for Pawnee Health and Wellness Clinic**

**1. I understand that my healthcare provider wishes me to engage in telemedicine consultations.**

**2. I understand that the video conferencing technology will be used to affect such a consultation and will not be the same as a direct patient/health care provider visit since I will not be in the same room as my healthcare provider.**

**3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare 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 healthcare provider and consulting healthcare 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 presences in the consultation and this 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. 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 healthcare provider.**

**6. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented and that I will be required to pay my applicable copay before the visit occurs. Our office staff will do their best to verify that the insurance covers telemedicine visits, however if this visit is deemed not as part of my medical benefits, I understand that I will be billed at the office visit cash price of $85.00 for a 15 minute or less visit for existing patients. Additional fees will apply for longer and more complex visits. I understand for new patient visits I will be charged the per insurance allowed amount if my insurance does not cover the visit.**

**7. For New Patients: I acknowledge that there are certain conditions that cannot be diagnosed without a detailed physical exam. This portion of the exam will be deferred until a date when I can be seen in the office. I understand that my physician will base their medical opinion and treatment recommendation on the absence of this exam and that the physician’s impression and plan may change after a formal in-office exam. I understand this and still wish to go forward with the telemedicine video visit.**

**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**By signing this form, I Consent to Telemedicine Visits as described above.

**Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient's DOB**

**\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Relationship if signing for the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today's Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telemedicine Consent Form** will be submitted to **Dr. Gordon Laird, DO**