Informed Consent for Franklin Clinic Telemedicine / Televisit Consultation

I am requesting to take part in a telemedicine consultation with The Franklin Clinic and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation. I understand the following:

1. The purpose is to assess and treat my medical condition.

2. The telemedicine consult is done through a two-way video HIPAA compliant link-up whereby the physician or other health provider at The Franklin Clinic can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. The Franklin Clinic and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. I can ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine visit and/or video conference be stopped at any time.

6. I know there are potential risks with the use of this technology. These include but are not limited to:
- Interruption of the audio/video link.
- Disconnection of the audio/video link
- A picture that is not clear enough to meet the needs of the consultation.
- Electronic tampering.

If any of these risks occur, the procedure might need to be stopped.

7. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by The Franklin Clinic.

8. In order to participate in the telemedicine program, I agree to pre-pay for these visits at time of scheduling with the front desk. No appointment will be booked without payment.

By signing this consent, I agree to the charges on my credit card or Care Credit. I understand these services are offered to **self-pay/commercial insurance and Medicare**. I, the undersigned patient, do hereby understand and state that I agree to the above consents and I am doing so of my own free will. I understand I can always opt for an in-person office visit. I certify that this form has been fully explained to me.
I have read it or have had it read to me. I understand and agree to its contents.

I volunteer to participate in the telemedicine examination. I authorize The Franklin Clinic and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Signature:_____ Date: _____

Printed Name: _____ Date: _____