Name:_____ **DOB:**_____

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

1. **PURPOSE.** The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in the diagnosis or treatment of:_____.

2. **NATURE OF TELEMEDICINE CONSULTATION.** Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

3. **RISKS, BENEFITS AND ALTERNATIVES.** The benefits of telemedicine include having access to your healthcare provider without having to travel outside of your community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician. The physician is not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that patient may require. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the video equipment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.

4. **BILLING:** We will file insurance claims on your behalf to the carrier(s) that you provided to us on your Patient Information Form. However, some insurance carriers do not reimburse for certain procedures and/or diagnosis. In the event a claim is filed and denied for charges not covered, you are ultimately responsible for all denied charges, copays, unmet deductibles, and coinsurance.

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered.

I have read and agreed to a telemedicine consultation.

Signature of Patient or Patient's Representative:_____ **Date:**_____

Relationship to Patient:_____

Witness:_____

REFUSAL: I refuse to participate in a telemedicine consultation as described above.

Signature: _____