CONSENT

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CONSENT TO PARTICIPATE IN A TELEHEALTH ENCOUNTER

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

I. DESCRIPTION, PURPOSE AND BENEFITS

I have been informed that video conferencing equipment will be used to provide a physician encounter via real-time interactive services. I also have been informed that the encounter will be somewhat different from an in-person patient encounter due to the fact that I will not be in the same room as my telehealth consulting physician. I understand that I will undergo a physical evaluation consistent with my presenting symptoms and that a medical assistant, nurse, physician's assistant or another clinician at the local site will present his or her findings to the physician providing the telehealth encounter. I further understand that I will have an opportunity to speak with the physician and ask questions.

I understand that individuals other than my healthcare providers may be present during the telehealth encounter in order to operate the video conferencing equipment, and that my protected healthcare information also may be shared for scheduling and billing purposes as such information is shared for in-person visits. I further understand that I will be informed of the presence of any non-medical personnel in the encounter area and will have the right to request the following:

i. omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain in the encounter area;
ii. ask non-medical personnel to leave the encounter area; and/or
iii. terminate the telehealth encounter at any time.

I further understand that either my health care provider(s) or I can discontinue the telehealth encounter at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case I will be referred to another healthcare provider for an in-person evaluation.

II. LIMITATIONS AND RISKS ASSOCIATED WITH THE TELEHEALTH CONSULT

I understand that certain limitations exist with a telehealth encounter including a provider's ability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio. I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth encounter. For these reasons, my particular medical needs may require an in-person encounter with a clinician. The physician performing the telehealth encounter or designee will inform me whether a telehealth encounter is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality. I also have been informed that certain medications such as narcotics may not be prescribed during a telehealth encounter.

The physician performing the telehealth encounter or designee also has explained to me that the usual and most frequent risks associated with this type of encounter include interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the encounter; and unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information.

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PATIENT LABEL HERE

III. ALTERNATIVE COURSES OF TREATMENT

The physician performing this telehealth encounter or designee has explained to me the reasonable alternative treatment or procedures and, as appropriate their usual and most frequent risks. I understand that the alternative to a telehealth encounter is a visit to another healthcare provider for an in-person evaluation, diagnosis and treatment which may not occur as quickly as a telehealth encounter can be performed.

IV. BILLING FOR THE TELEHEALTH CONSULT

I understand that billing for this telehealth encounter will consist of both a consulting fee from the physician performing the telehealth encounter and a facility fee from the site from which I am presented for the encounter. I further understand that available third party insurance will be billed for such services, and that billing statements will be mailed to me following the telehealth encounter with any remaining balances. I further understand that a co-payment is due at the time of the encounter if I am insured with a commercial payor.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to this telehealth encounter, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in the telehealth services described herein for purposes of examination, encounter, diagnosis and treatment.

X _____ AM|PM _____ X _____

Signature of ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative | Date| Time | Witness Signature

Printed name of person signing on behalf of the patient: _____ Patient is a ❑ Minor or _____

Consent given by telephone ❑ Patient ❑ Other _____ Telephone #_____

Printed name of interpreter _____ Reason ❑ Sign ❑ Language ❑ Other _____

X _____ _____ _____

Signature of Physician or Designee | Date| Time | Printed Name

Verification of Patient Identity:

❑ State Driver's License ❑ State Identification Card ❑ School/College Identification Card ❑ Passport ❑ Other

❑ Established Patient