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INFORMED CONSENT FOR TELEMEDICINE CONSULTATIONS

Patient Name:	DOB
Patient Location:	Med. Record #

Physicians Name:	Location:
Provider Name:	Location:

Date of Consent:

To better serve the needs of individuals in the community, health care services can be made available by interactive video communications and/or by electronic transmission of information. This may assist in the evaluation, diagnosis, management of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means you may be evaluated and treated by health care provider/specialist from a distant location. As this type of consultation/visit with a provider may be different than health care services you are familiar with, it is important you understand and agree to the following statements.

1. The consulting health care provider will be at a different location from me. A physician or other healthcare provider may be present in the room to assist in the consultation.
2. The presenting practitioner may transmit or share details of my medical history, examination, x-rays, tests photographs or other images electronically with a provider who is at a different location.
3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the presenting practitioner and via video, the consultant. I will give my verbal permission prior to the entry of additional personnel.
4. The physician or healthcare provider for whom on-site examination or treatment is performed (the "presenting practitioner") will keep a record of the consultation in my medical record.
5. RELEASE OF INFORMATION: Practitioners who provide professional services are authorized to furnish medical information to the referring physician, to any insurance company or third party payer for purpose of obtaining payment of the account. I authorize the release of information from my medical record to any other healthcare facility or provider to which my care may be transferred.
6. I voluntarily consent to healthcare services provided by my doctor(s) or designee's, which may include diagnostic tests, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problems.
7. I understand I may be released before all my medical problems are known or treated, and it is my responsibility to make arrangements for follow-up care or seek additional healthcare in the event of an emergency.

8. I understand I have the option to refuse telehealth services at any time without affecting the right to future care or treatment.
9. I understand a variety or alternative methods of medical care may be available to me, and I may choose one or more of these at any time.
10. I understand 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.
11. I understand the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

ASSIGNMENT OF BENEFITS: I and/or my insurance carrier(s) agree to pay, in a timely manner, for emergency health care services provided. I authorize payment directly to the provider providing telehealth benefits paid directly to provider.
The benefits assigned include, but are not limited to the following:

- Primary and secondary benefits for all medical and hospitalization insurance, accident insurance, Medicare, Medicaid, and any benefits payable by alternative delivery systems such as PPOs, HMOs, POSs.
- Benefits arising from any workers' compensation or occupational disease claims and proceeds to which I am, or my estate is, entitled because of any claim or cause of action for damages against any person or organization.

FINANCIAL RESPONSIBILITY: In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insured or third party payer, including any deductible or copayment, or any charges not covered as a result of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third party payer. Should my account be referred for collection, I agree to pay reasonable attorney fees and collection expenses.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ________________________________ (name of physician) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient/Representative: _____________________________ Date: ___________________________

Patient Printed Name: ____ D.O.B.__________________________

If authorized signer, relationship to patient: ______________________

Time: _________________________ Site Location: ______________________

I have been offered a copy of this consent form (patient's initials) ________