FAMILY PODIATRY CENTER

Telehealth Consent

Patient Name: _____ Date of Birth:_____

Location of the Patient: _____ Date Consent_____

Provider Name:_____ Location:_____

Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio and video telecommunication system that permits real-time communication to persons who are at some distance from the provider to enable patients to receive medical care by a provider.

Privacy and Security: I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

Nature of Telehealth Consultation: I consent to Dr. Reid and/or Dr. Kosova who explained to me how the video and conferencing technology will be used for purposes including discussion and diagnosis including follow up monitoring my examination/procedure/treatment and for advice and education.

Medical Records: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

Alternatives: I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction. I understand that as a result of this telehealth visit, I may be required to visit the office.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact

Rights and responsibilities: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers. Virtual Visits and telehealth services may not be available for all plans. I accept the financial responsibility of telehealth visits if my insurance company does not approve the charge. My questions regarding this service have been answered and I consent to a telehealth appointment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative Relationship to Patient

_____ _____

Signature of Provider Witness to Signatures