Howard Medical Corp

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Consent To Participate in Telemedicine Consultation

1. **PURPOSE:** The purpose of this form is to obtain your consent for a telemedicine consultation with a medical provider. The purpose of this consultation is to assist in the diagnosis or treatment of a medical or possibly medical issue.
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 medical specialists and additional medical information and education without having to travel outside of your local health care 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. 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 medical provider.
4. **TEACHING AND RESEARCH:** HOWARD MEDICAL CORP is not a teaching institution. However, your provider may have physician residents, interns, medical students, students of ancillary health care professions (i.e., psychologist, nurse practitioner, nursing, physical and rehabilitation therapy) or post-graduate fellows participate in telemedicine consultations, under the supervision of the supervising medical provider, as part of a healthcare education program. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask the student or non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. **MEDICAL INFORMATION AND RECORDS:** All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent. Additionally, non-medical technical personnel may participate in the telemedicine consultation to aid in the audio/video link with the provider.
6. **EMERGENCIES:** In an emergent consultation or situation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, local hospital, or local emergency services and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. **CONFIDENTIALITY:** All existing confidentiality protections under Federal and your individual state law apply to information used or disclosed during your telemedicine consultation.
8. **BILLING:** I understand that billing will occur at time of service. I also understand that I will be billed for any missed appointments that are not cancelled within 48 hours of the appointment time.
9. **RIGHTS:** You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the consultation(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient or Patient's Representative	Date of Signing
Relationship of Representative to Patient	Name of Interpreter / ID #
Signature of Witness (required if patient is unable to sign)	Date of Signing

REFUSAL: I refuse to participate in a telemedicine consultation as described above. Please note that by refusing we will be unable to complete your request to be treated by a healthcare provider using our telehealth system. If you are experiencing an emergency please go to the nearest emergency room or immediately call 911.

Signature of Patient or Patient's Representative	Date of Refusal