Informed Consent for Telemedicine Services

PATIENT NAME: _____ LOCATION OF PATIENT: _____

DATE OF BIRTH: _____MEDICAL RECORD #: _____PHYSICIAN NAME: _____

Medicare ID# : _____DATE CONSENT DISCUSSED: _____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers to begin/ continue treatment of patients for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records

· Medical images

· Live two-way audio and video

· Output data from medical devices and sound and video files

Your appointment will be facilitated with the use of Skype or Apple Facetime as recommended by the U.S. Department of Health & Human Services. As recommended by the department, we need to inform you that these third-party applications potentially introduce privacy risk.

Expected Benefits:

· Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the physician consults from a distance/in-office; and obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

· Delays in medical evaluation & treatment could occur due to deficiencies or failures of the equipment;

· In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

· In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment error

Please initial after reading this page: _____

Informed Consent for Telemedicine Page 2

1. I understand that 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.
2. I understand that 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.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. 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 dermatologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my dermatologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that Westchester Center for Dermatology will be billing insurance for this visit (except for Medicare patients). The fee will be $75.00 for no-insured patients and is non-refundable. If it is necessary for me to come into the office for a procedure, that will be billed through my insurance if it's one with which the office participates.

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 dermatologist***) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____ *Date:* _____

If authorized signer,

relationship to patient: _____

Witness: _____ *Date:*_____

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

Credit Card information

Credit Card #: _____

Name on Credit Card: _____

Expiration Date: _____

Security Code: _____

Zip Code: _____

I authorize Westchester Center for Dermatology to charge the listed card for $75.00 (for non-insured patients) or my co-pay dictated by my insurance company.

Sign: _____

Virtual Appointment Request with Dr. _____ for concerns of _____

_____

Demographic Information

First and Last Name: _____

Phone Number (home/cell):_____

Street Address: _____

City, State & Zip Code: _____

Email: _____

FOR MEDICARE PATIENTS ONLY, Medicare ID #: _____

By signing, I acknowledge that I am not a Medicare patient and I am agreeing to pay the $75.00 out-of-pocket cost associated for this virtual appointment.

Sign: _____

History of Present Illness/ Concern:

_____

Area affected: _____

When did it start/ first appear? _____

How long has it been present? _____

What symptoms are you experiencing? _____

Do you have any photos attached to this email? _____

If so, please attach.