

Louetta Family Medicine

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
2. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
 - a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
 - b. Telemedicine will have a limited evaluation in comparison to an in-person examination.
3. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
4. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
 - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I will be financially responsible if my insurance will not cover this service.
 - c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
5. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally consented evaluation by telemedicine and have read this form and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name

Patient/Parent/Guardian Signature

Date