



## **Telemedicine Informed Consent**

1. I understand that my health care provider wishes me to engage in a telemedicine consultation
2. My healthcare provider has explained how the video conferencing technology will be used and that consultation will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider.
3. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider is doing everything possible to assure a secure interaction. I understand that my healthcare provider or I can discontinue the telemedicine visit if it is felt that the video conferencing connections are not adequate for the situation.
4. I understand that my information may be shared with other individuals for scheduling and billing purposes. These people will all maintain confidentiality of the information obtained.
5. I have had alternatives to telemedicine consultation explained to me, and I am choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of my healthcare provider.
6. I understand that insurance billing will occur from my practitioner. All required co-pays will be waived.
7. I understand that I will be in a direct conversation with my healthcare provider, during which I have the opportunity to ask questions in regard to this procedure. Any questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.