



## Informed Consent for Telemedicine Services

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.

I understand that electronic communication should never be used for emergency communications, time sensitive matters, or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by my employer, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

I understand that the laws that project privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations; including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided through telemedicine.

I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

I understand that I will be responsible for any copayments, deductibles or coinsurances that apply to my telemedicine visit.

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 effecting my right to future care or treatment.

I have read and understand the information provided above regarding Telemedicine, 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, and authorize Orlando Family Practice Care, P.A to use telemedicine in the course of my diagnosis and treatment.

Patient Name:

Date:

Patient Signature:

Witness: