DEC-PA, LLC Telemedicine/Telehealth Consent

PATIENT NAME: _____ DATE OF BIRTH: _____

PHYSICIAN NAME: _____ DATE CONSENT OBTAINED: _____

The purpose of this form is to obtain your consent for a Telehealth visit with the physician at DEC-PA, LLC. Telehealth is medical care provided by any means other than a face-to-face or in-person visit. During a Telehealth, medical and mental health information is exchanged interactively from one site to another through electronic communications or a technology-assisted format and is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that…

1. 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 my coverage and follow DEC-PA's Financial Office Policy.
2. Telehealth may involve electronic communication of my personal medical information to other medical providers who may be in other areas, including out of state.
3. Electronic communication may be used to communicate highly sensitive medical information.
4. All electronic medical communications carry some risks which include but are not limited to:
   - Security protocols may fail, causing a breach of privacy of my personal medical information.
   - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
   - Information transmitted via telehealth may not be sufficient (e.g., poor resolution of images) and may limit my physician's ability to fully diagnose a condition or disease.
   - Delays in medical evaluation and treatment could occur due to limitations, deficiencies or failures of the equipment used.
   - Lack of access to complete medical records may result in adverse drug interactions, allergic reactions, prescription refills may not be possible, and appointment(s) may need to be rescheduled.
5. I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office. If I do opt out, there may be a delay in receiving in-person services, prescription refills etc. as per changing restrictions.
6. I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
7. My physician is not responsible for breaches of confidentiality caused by an independent third party or by me.
8. Federal and state laws that protect the privacy and confidentiality of medical information also apply to Telemedicine. This includes my right to access my own medical records (and copies of medical records) with applicable fees.
9. Electronic communication should never be used for emergency communications or urgent matters. Emergency communications should be made to the provider's office or to the existing emergency 911 services.

Patient Consent to The Use of Telemedicine

I have read and understood the information provided above regarding Telemedicine, have discussed it with my physician or his designated assistant(s), and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient/Legal Representative (circle one) Signature_____

Physician/ Practice staff obtaining Consent:

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician/Practice staff Initial (check one): AC AS NW BK CD