Consent to Participate in Telehealth Consultation

1. I understand that my health care provider wishes me to engage in a telemedicine consultation, and potentially ongoing care through telehealth.
2. Video conferencing technology will be used to affect such a consultation that will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider. Audio only telehealth may be offered in lieu at my provider's discretion, and as allowed by regulation.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I will be expected to the best of my ability to access a stable connection, a private location, and provide my undistracted attention during my visit. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the circumstances are not adequate for the situation, and an alternative may be offered.
4. I understand that others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (l) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask nonmedical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have alternatives to a telemedicine consultation, and in 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 the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have the opportunity to ask questions regarding my treatment at any time. I understand the risks, benefits, and any practical alternatives which I may request or discuss with my provider at any time.

Additionally, although VAMED has taken substantial steps to ensure the confidentiality and privacy of medical care and information provided through telehealth, there are inevitable risks to the security of any internet transmissions or communications. I understand that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

By signing this form, I certify:

* That I have read or had this form read and/or had this form explained to me
* That I fully understand its contents including the risks and benefits, and my responsibilities pertaining to participation in telehealth.
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____

Patient Signature