OGNOMY

TELEMED CONSENT

Please review the following. By signing below, you are acknowledging that you have read or had this form explained to you, you fully understand its contents including the risks and benefits, and have been given ample opportunity to ask questions and any questions have been answered to your satisfaction.

- ⇄ The health care provider wishes to engage with you in telemedicine consultation.
- ⇄ Video conferencing is not the same as a direct patient/healthcare provider visit as the provider will not be in the same room as you.
- ⇄ There are potential risks to use of this technology including interruptions, unauthorized access, and technical difficulties.
- ⇄ You , or the provider, can discontinue the telemedicine visit if it is felt that video conferencing connections are not adequate.
- ⇄ Healthcare information may be shared with other individuals for scheduling and/or billing purposes as well as for coordination of any testing or services ordered.
- ⇄ Other individuals may be present during the conversation other than my provider in order to operate the video equipment. You will be informed of their presence in the consultation and have the right to
    1. Omit specific details of my medical history or physical exam that are personally sensitive
    2. Ask non-medical personnel to leave the telemedicine exam room
    3. Terminate the consultation at any time
- ⇄ Alternatives to telemedicine are available and can be discussed at your request.
- ⇄ You will be billed for telemedicine services and will be responsible for fees not covered by your insurance company (i.e. visit co-pays, or co-insurance obligations).
- ⇄ You have had a direct conversation with the providing office during which you had the opportunity to ask questions in regard to this procedure. Your questions have been answered and the risks, benefits, and any practical alternatives have been discussed with you.

Patient's Name (printed):

_____

Patient/Parent/Guardian Signature_____

Date:_____