Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. I understand that my insurance carrier will have access to my medical records for quality review/audit.
7. I understand I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit. I also understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I have personally read this form and full understand and agree to its content; have had my questions answered to my satisfaction; and am located in the state of Texas and will be during my telemedicine visit.

Patient Signature: ___________________________________ Date: ____________________