Telemedicine Consent

Patient Name: _____ DOB: _____

1. In light of current COVID-19 pandemic I wish to engage in a telemedicine consultation with Dr. Robert Klausner.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I have been advised of the potential risks and limitations of this mode of treatment (including but not limited to the absence of in-person examination) and agree to be treated in a remote fashion in spite of them
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained.
5. I have had the alternatives to a telemedicine consultation explained to me, 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 to seek care at an emergency room or call 911 is my responsibility.
7. I understand that billing will occur from my physician and I am responsible for all deductibles, copays and coinsurance that my carrier does not cover just as I would be if I were seen in person..
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By emailing or texting "agree" and/or signing this form, I indicate my agreement and 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 of the procedure(s), and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____
Patient's/parent/guardian signature or printed name Date Time

_____ _____ _____
Witness signature and printed name Date Time