TELEHEALTH ACKNOWLEDGMENT

1. I understand that my healthcare provider, _____, has recommended to me that I engage in a telehealth appointment with _____ (provider).

2. My healthcare provider has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my healthcare provider. I understand that the healthcare provider may use devices such as a stethoscope or otoscope or other peripheral devices to assist in the examination.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.

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 appointment other than my healthcare provider and specialty healthcare provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty healthcare provider or the primary care provider.

6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

_____ _____ _____
Patient/Resident/Legal Representative Signature Date Time

If signed by patient/resident representative, complete the following: ❍ Mobile ❍ Home ❍ Office

_____ _____ ( ) _____
Print Name Relationship Phone

_____ _____ _____
Witness Signature/Title Date Time

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed ❑ Home

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