Telemedicine Informed Consent Form

I _____[name of patient] hereby consent to engaging in telemedicine with Dr. Chris Davis, Dr. Lauren Davis, or Claire Liston as part of my medical treatment. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/ mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of Dr. Chris Davis, Dr. Lauren Davis, and/or Claire Liston, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/ or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my healthcare provider believes I would be better served by face-to-face services, I will be asked to come into the office. Finally, I understand that there are potential risks and benefits associated with any form of medical therapy, and that despite my efforts and the efforts of Dr. Chris Davis, Dr. Lauren Davis, and/or Claire Liston, my condition may not be improve, and in some cases may even get worse. If I do not improve with the treatment initiated in my telemedicine visit, I will come into the office for a face-to-face encounter.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

(6) I understand that my insurance will be billed in the same way as I would be billed in a face-to-face encounter and that I will be financially responsible for my copay and my remaining balance following my normal insurance write-offs. If Dr. Chris Davis, Dr. Lauren Davis, or Claire Liston recommend I come in for a face-to-face visit in their office, I will not be charged for my telemedicine visit, unless I fail to come in as recommended. If I fail to pay my bill in a timely manner, I understand that I will be sent to collections.

I have read and understand the information provided above. I have discussed it with Dr. Chris Davis, Dr. Lauren Davis, and/or Claire Liston, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of patient/parent/guardian/conservator If signed by other than patient indicate relationship

_____

Date

Dr. Chris Davis, DO Dr. Lauren Davis, DO Claire Liston, NP