Alexandra Pellicena, MD
OBSTETRICS & GYNECOLOGY

PATIENT CONSENT FOR TELEMEDICINE AND TELEHEALTH SERVICES

I have been asked by Dr. Alexandra Pellicena to receive telemedicine services. The purpose is to assess and/or treat my medical conditions. This is done through a two-way audio/video link with the physician. I understand that:

1. I will talk through the audio/video link with the physician.

2. I can ask that the exam and/or audio/video link be stopped at any time.

3. The potential risks and benefits have been discussed with me. I understand these may include (but are not limited to):

Potential Benefits:

Increased accessibility to specialty services

Convenience for me

Potential Risks:

a. Interruption or disconnection of the audio/video link
b. A picture that is not clear enough to meet the needs of the evaluation
c. Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment
d. The audio/video link is conducted through the internet. There is a small chance that someone could tap into this session, if security protocols fail.
e. A lack of access to all the information that might be available in an in person visit. This could lead to errors in medical decision making.

4. If any of these risks occur, or if the distant site provider determines there is a reason for me not to participate, then the telemedicine or telehealth service might need to be stopped.

5. I authorize the release of any relevant medical information that pertains to me to Dr. Pellicena. This information may include my name, age, birth date, or other information that is necessary to conduct this telemedicine or telehealth service.

6. I understand that this service will become part of my medical record kept by Dr. Pellicena.

7. I understand that I will not receive any royalties or other compensation for taking part in this service.

8. I understand that I must give my informed consent to participate in this service.

9. I acknowledge that I have received Dr. Pellicena's notice of Privacy Practices, or that I have reviewed the notice on the practice's website.

10. I know how to contact the Texas Medical Board (1-800-201-9353) if I am seeing a doctor and have a complaint, and understand that this information is also posted on the Dr. Pellicena's office

11. I understand that my insurance, if appropriate, will be billed as a courtesy and that I will be responsible for any balance. I understand that some private insurance companies are not agreeing to pay for televisits but that it is my responsibility to know my own coverage. I understand that I must reside or be physically located in the state of Texas while having a televisit. By signing this consent, I agree to the charges on my credit card based on my insurance rates, copays, or the explained self-pay rates

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand its contents, and I give my consent to receive telemedicine and telehealth services. This consent remains in effect unless revoked in writing.

Signature of Patient: _____Date:_____

Signature of Witness:_____Date:_____