TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I, _________________________, understand Telehealth services provided by HopkinsMD is a service that involves medical/mental health information via an electronic format, chosen by aforementioned company. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me. I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

I understand that telehealth billing information is collected in the same manner as a regular office visit. However, cash pay, fee-for-service arrangements may apply where telehealth services are not covered under a patients' health plan. My financial responsibility will be determined individually and governed by my insurance carrier(s), or Medicare, and it is my responsibility to check with my insurance plan to determine coverage.

I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For communication between Dr. T. Hopkins or A. Johnston, FNP, staff, and ______________________.

(Healthcare provider's name) *(Patient's name)*

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Patient or Legal Representative Signature/Date/Time Relationship to Patient

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Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained. Copy given to patient and original placed in chart.

____ ______________________________

Healthcare Provider Signature Date/Time