Interior Women's Health
1626 30th Ave.
Fairbanks, AK 99701

Phone: 907.479.7701
Fax: 907.479.7718

Telemedicine Consent

Patient Name:		Date of Birth:
Primary Phone	E-mail **(Print Clearly)**	

Authorization and Information

1. The purpose of this consent is to obtain your consent to participate in a telemedicine consultation with Interior Women's Health (IWH).
2. I understand that the laws that protect privacy and confidentiality of medical information apply to telemedicine.
3. I am asking Interior Women's Health and it's agents to provide a real-time evaluation, consultation, and treatment using telemedicine. This includes the use of interactive audio, video, or electronic media. This will allow the provider to see and communicate with the patient in real-time.
4. I understand that IWH may determine that the telemedicine service may not address my medical needs and they may require that I have an evaluation in-person.
5. I understand that it is my responsibility to communicate, to the best of my ability, information about my medical history, condition and care that is complete and accurate.
6. If I experience an urgent matter such as a bad reaction to any treatment after my telemedicine encounter I will notify my provider immediately. In the case of an emergency I understand I will need to dial 911 or present to the nearest hospital emergency department.
7. I voluntarily request and authorize the disclosure of all my medical record information (including oral information) to IWH providers. I understand this may include information related to
   A. AIDS/HIV test results, diagnosis, treatment
   B. Drug and Alcohol use and treatment
   C. STI test results, diagnosis, treatment
   D. Mental Health information
   E. Genetic information
8. I understand that the disclosure of medical information to IWH providers, including audio and/or video will be transmitted electronically. I further understand IWH has taken precautions to protect the confidentiality of this information but because this service is new and developing my confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

Patient Acknowledgement

Please initial below

______ It is my responsibility to contact my insurance plan(s) **BEFORE** services are provided regarding coverage and benefit information for telemedicine services. IWH is unable to obtain this benefit information on my behalf. I fully understand my insurance plan(s) may only cover telemedicine services with specific telemedicine providers utilized through an existing telemedicine networks associated with my health insurance plan.

______ ***All IWH financial policies will remain in effect and will apply to telemedicine encounters.*** I will be required to pay any patient cost shares assigned by my insurance plan at the time of service. Furthermore, in the event my insurance plan denies my telemedicine visit I will be responsible for payment in full.

Consent

I certify that this form has been fully explained to me and I have read it or had it read to me. I understand its contents all questions and/or concerned have been addressed.

______________________________	______________	______________________
Patient Signature	Date	Relationship to Patient