INFORMED CONSENT FOR TELEMEDICINE VISITS

Telemedicine involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing and/or referring the patient to in-person care, as determined clinically appropriate. This Telemedicine Informed Consent informs the patient concerning the treatment methods, risks and limitations of using a telemedicine platform through Hines Dermatology Associates, Inc.

I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that providers are not able to connect me directly to any local emergency services.

I understand there is a risk of technical failures during the telemedicine encounter beyond the control of the practice. I agree to hold harmless for delays in evaluation or information lost due to such technical failures.
In rare cases, information transmitted may not be sufficient (e.g. poor image resolution) to allow for appropriate medical decision making by the physician and consultant(s).

I understand in very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

I understand I may expect anticipated care benefits from use of telemedicine, but results cannot be guaranteed or assured.

I understand that there may be a co-pay/cost for the visit.

I understand persons may be present during the consultation other than my Provider in order to operate telemedicine technologies. I understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine exam; or (3) terminate consultation at any time.

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I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Hines Dermatology Associates, Inc. will take steps to ensure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my person medical information to other health practitioners engaged by Hines Dermatology Associates Inc. who may be located in other areas.

Verbal consent from the patient for a telemedicine visit was obtained at the time of the service. The patient understands not all conditions can be adequately evaluated and treated through a virtual visit and may require an in-person medical evaluation.

Patient's Verbal Consent Obtained by: ___________________________________

Date: ________________________________ Time: ________________________