BOCA DERM

CONSENT FOR NON-FACE TO FACE "VIRTUAL" VISITS

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Time: _____

I, _____hereby voluntarily consent to receive "virtual" care. Examples of the virtual services offered at BOCA DERM include:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether or no an in person visit or other appropriate treatment is needed.

E-Visits: You may communicate with your treating provider through **DOXY.ME.**

I understand that this consent form will be valid and remain in effect as long as I receive medical care at **BOCA DERM.**

"Virtual Visits" mean that you may be evaluated and treated by a healthcare provider from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the provider. _____ **{Initial Here}**
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording. _____**{Initial Here}**
- I understand there are potential risk to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation. _____ **{Initial Here}**
- I understand that I may be disconnected before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care. _____**{Initial Here}**
- I understand that the standard deductible and coinsurance amounts applied to these "Virtual Visits" and I consent to virtual treatment. _____**{Initial Here}**

This form has been explained to me and I fully understand this consent for non-face-to face "Virtual Visits" and agree to its contents.

Signature of patient or person authorized to consent for patient:

_____ _____

Name **Date**