Family Doctors
MEDICAL CENTER

Telemedicine Consent/ Telemedicine Care and Treatment Form

Introduction: Telemedicine involves the use of electronic communications, both audio and video, to enable your provider at Family Doctors Medical Center to evaluate, diagnose, and treat you from a remote location.

Benefits: The benefits of a telemedicine are to improve access to medical care by enabling a patient to remain in his/her home while accessing the medical provider at Family Doctors of Green Valley to access medical expertise quickly, efficiently, and without travel.

By electronically signing below I understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine visits, and that no information obtained in the use of telemedicine will be disclosed to researchers or other entities without my written consent.
2. I understand the alternatives to telemedicine consultation such as an on-site visit, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests/touch may be not be conducted.
3. I understand that I may expect the anticipated benefits from the use of telemedicine with my care, but that no results can be guaranteed or assured.
4. I understand if the telemedicine provider determines that telemedicine services do not adequately address my medical needs, the telemedicine providers will refer me for an on-site medical evaluation at a Family Doctors Medical Center location.
5. I understand if after the telemedicine services, I experience an urgent or emergent matter, or if the telemedicine session is interrupted due to a technological or equipment failure, it is my responsibility to seek alternatives to my care such as, but not limited to, a physical visit at a Family Doctors Medical Center location.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider. The above mentioned person will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) ask non-medical personnel to leave the telemedicine examination room; and/or (2) terminate the consultation at any time.
7. I understand this telemedicine consultation will be billed for services rendered, I understand and agree to pay all professional charges not covered by insurance. I also agree to pay all collection fees necessary for this telemedicine on the date of service rendered.

Duration of Consent: I understand and agree this consent for telemedicine with Family Doctors Medical Center. Care and Treatment is valid from the date present and future visits for one year from the date of signature below unless I revoke the consent prior to that time.

By electronically signing below I have read and understand the information in this Consent for telemedicine care and treatment form.

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____