Foothills Health & Wellness Center

TELEMEDICINE INFORMED CONSENT FORM

PATIENT INFORMATION

Patient Name:_____ **DOB:** _____

Site Where Patient is Seen via Telehealth: Estill Outreach Office

Consulting Provider Name Seeing Patient via Telehealth:

Provider Location:
100 Tyler Lane, Irving, KY 40336

INTRODUCTION

By signing this consent form you are consenting to have clinical encounters using audio or videoconferencing technology. When using videoconferencing technology, you will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky. The information may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being implemented to insure that this videoconference is secure, and no part of the encounter will be recorded without your written consent. [During the COVID-19 pandemic the use of audio only technology is available when videoconferencing is not accessible.]

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems could delay or prohibit encounters for medical evaluation and treatment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entitles without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care of treatment.
3. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I agree that I am responsible to pay for charges resulting from the services rendered using audio or videoconferencing technology. What you pay depends on your insurance as this visit will not cost any more than an office visit.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize *Foothills Health and Wellness Center* to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or authorized person): _____ **Date/Time:** _____

If authorized signer, relationship to Patient: _____

Witness:_____ **Date/Time:** _____

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