Telemedicine Informed Consent

Consent for Telemedicine Services:

I, _____, hereby consent to engage in telemedicine services with Health Family Services of Texas. I understand and agree with the following:

- Telemedicine services involve the use of electronic communications to enable healthcare providers to obtain information for the purpose of evaluation, diagnosis, consultation, treatment, and education.
- The same standard of care applies to telemedicine services as does an in-person visit.
- I will not physically be in the same room as my healthcare provider during the telemedicine visit.
- I will be notified of, and my consent obtained if anyone other than my healthcare provider is present during the telemedicine visit.
- There are potential risks to using technology, including service interruptions, interceptions, and technical difficulties.
- Healthy Family Services will use a HIPPA compliant telemedicine platform to conduct my visit which will include two-way audio and video capabilities.
- If the telemedicine platform and/or connection is not adequate, my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I have the right to refuse to participate or decide to stop participating at any point in a telemedicine visit and my refusal will be documented in my medical record.
- The laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.
- My insurance carrier will have access to my medical records for quality review/audit.
- I will be responsible for any out-of-pocket expenses such as copayments or coinsurances that apply to my telemedicine visit.
- My health plan payment policies for telemedicine services may be different from policies for in-person visits.
- I must be physically located in the state of Texas during my telemedicine visit.
- This document will become part of my medical record.
- This authorization is voluntary.

By signing this form, I attest that I have personally read this form or had it explained to me, I fully understand and agree with the contents of this document, my questions answered to my satisfaction, and that the risks, benefits, and alternatives to telemedicine services have been shared with me in a language I understand.

_____ _____

Patient/Parent or Legal Guardian Printed Name Patient/Parent or Legal Guardian Signature

_____ _____

Witness Signature Date