Name:

DOB:

Date:

Telemedicine Informed Consent Form

Site where patient is being seen via telehealth: ______________________

Consulting Provider's name: ______________________

Provider location: ______________________

You are going to have a clinical visit using video conferencing 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.

Expected Benefits:

*Patient remains closer to home or an accessible location where healthcare providers can maintain continuity of care.

*Reduced need to travel for the patient or the 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 technology and schedule a traditional face-to-face encounter at any time. Safety measures have been implemented to ensure that this video conference is secure, and no part of the encounter will be recorded without your written consent.

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 the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.

*Technology problems may delay medical evaluation for today's encounter.

*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 entities 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 or treatment.
3. I also 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 understand that the video conference visit will be billed to my health insurance company. I will be billed for any patient responsibility per my insurance.

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 OrthoCincy my informed consent for the use of telemedicine in the course of my diagnosis and treatment.

Signature (Patient)	Date	or	Signature (Legal Representative)	Date
Printed			Relationship to Patient	
Witness	Date			