CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

Patient's Name: _____ Patient's Date of Birth: _____

1. I understand that my health care provider, Rob Deckert, wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

5. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

6. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented, unless the originating site is my home.

7. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

8. I understand that my insurance will be billed for this service and any uncovered and out of pocket costs are my responsibility and I will remit payment to the provider.

_____ _____

Patient's/parent/guardian signature Date and Time

_____ _____

Witness signature Date and Time