Piedmont Family Practice Telemedicine Consent Form

Patient Name: _____ Birthday: _____ .

1. My health care provider has explained to me how that telemedicine video conferencing technology 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.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
4. I have had the alternatives to a telemedicine consultation explained to me. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
5. I understand that billing may occur from both my practitioner and as a facility fee from the site from which I am presented.
6. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____
Patient's/parent/guardian signature	Date	Time
_____	_____	_____
Witness signature	Date	Time

5/2015