

CONCIERGE MEDIAL SERVICES

INFORMED CONSENT FOR TELEMEDICINE SERVICES DURING COVID-19 PANDEMIC

Patient Name _____

Date of Birth ____/____/____ Medical Record # _____

Physician Name _____ Date Consent Discussed ____/____/____

Location _____

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, in order to ensure greater access to care while limiting the spread of COVID-19, the mode of communication used during your telehealth consultation may not be secure and may be subject to privacy risks.

Anticipated Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site
- Limiting the spread of COVID -19
- More efficient medical evaluation and management
- Ability to obtain consultation of a distant specialist
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By Signing this Form, I Understand the Following:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that during the COVID-19 Pandemic, security measures may be lessened in accordance with U.S. Department of Health and Human Services (HHS) to ensure improved access to care.
4. I understand that I have the right to withhold or 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.
5. I understand there may be technological challenges that prevent recording the telemedicine interaction during the COVID-19 pandemic, but that I have the right to inspect all information obtained and successfully recorded and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.

7. I understand that the telemedicine visit may occur with a licensed medical provider who is not licensed in my state of residence. I also understand there may be electronic communication of my personal medical information to other medical providers who may be located in other states.

8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

9. I understand that certain fees for service may be waived during the COVID-19 Pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I may be responsible for any copayments or coinsurances that apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost, I will be responsible for payment.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine during the COVID-19 Pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

I hereby **authorize** _____ (*name of physician*) to use telemedicine in the course of my diagnosis and treatment.

Patient **Signature** (or person authorized to sign for patient) _____ Date ____/____/____

If authorized signer, relationship to patient

Witness _____ Date ____/____/____

I hereby **refuse** _____ (*name of physician*) to use telemedicine in the course of my diagnosis and treatment.

Patient **Signature** (or person authorized to sign for patient) _____ Date ____/____/____

If authorized signer, relationship to patient

Witness **Signature** _____ Date ____/____/____

I have been offered a copy of this consent form (patients initials)_____

**After you have completed filling in this form, print, sign, scan and email to: JMarinelli@manasotamed.com
OR print, sign and mail to: 1250 South Tamiami Trail, Sarasota, FL 34239.**



PRICE & TRAVNICEK

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