ROSEMAN MEDICAL GROUP

INFORMED CONSENT TO PARTICIPATE IN A TELEMEDICINE VISIT/ CONSULTATION

Patient's Name: _____ DOB: _____

1. In an effort to ensure continuity of care and patient safety, I am requesting a telemedicine visit with (clinician name)_____, a Roseman Medical Group provider.

2. My health care provider has explained to me how the video and/ or audio- conferencing technology will be used to affect such a visit I understand that this visit/consultation will not be the same as a direct patient/health care provider visit because 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 or I can discontinue the telemedicine consult/visit if it is felt that the video and/or audio-conferencing 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. Others may also be present during the visit/ consultation other than my health care provider and consulting health care provider in order to operate the video equipment and/or assist in the examination. 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.

5. I understand that some parts of the exam involving physical exam or testing may need to be conducted by individuals at my location at the direction of the health care provider.

6. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented. There may be a co-pay associated with this telemedicine visit (depending on my insurance).

7. I have read this document carefully and understand the risks and benefits of the video and/or audio- conferencing visit and have had my questions regarding the visit/ consultation explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

Patient's/parent/guardian signature Date

Patient is unable to sign this form, but has verbally attested to this visit/ consultation at this time.

_____ _____

Signature of RMG Staff Member Date