Televisit Informed Consent for Dr. Trujillo, Dr. deSchweinitz and FNP Carson-McCollum

I am requesting to take part in a telemedicine visit with the above listed providers, technical assistants and others deemed necessary to assist in my medical care through a telemedicine visit. I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine visit is done through a two-way video HIPAA compliant link-up whereby the physician or other health provider can see my image on the screen and hear my voice. However, unlike a traditional medical visit, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit. Since the telemedicine providers do not have the opportunity to meet with me face-to-face, they must rely on information provided by me. The above listed providers cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
3. I can ask questions and seek clarification of the procedures and telemedicine technology.
4. I can ask that the telemedicine visit and/or video conference be stopped at any time.
5. I know there are potential risks with the use of this technology. These include but are not limited to: Interruption of the audio/video link. Disconnection of the audio/video link. A picture that is not clear enough to meet the needs of the consultation. Electronic tampering.If any of these risks occur, the procedure might need to be stopped.
6. I will not receive any royalties or other compensation for taking part in this telemedicine visit or associated with any use by the above listed providers.
7. In order to participate in the televisit program, I agree to pay for these visits at the current established rates of the practice.

By signing this consent:

I agree to the charges that may be billed to my insurance and/or account.

I understand it is my responsibility to verify insurance coverage for this service.

I, the undersigned patient, do hereby understand and state that I agree to the above consents and I am doing so of my own free will. I understand I can alternatively opt for an in-person office visit. I certify that this form has been fully explained to me. I have read this form or have had it read to me. I understand and agree to its contents.

I volunteer to participate in the televisit examination. I authorize the above listed providers, technical assistants and others deemed necessary to arrange for and perform procedures that may be necessary for my current medical condition.

Printed Name: _____

Signature: _____

Date: _____