Advance Health Integrative Medicine
Telemedicine Consultation Consent

Patient Name: _____

1. I understand that I will be engaging in a telemedicine consultation.
2. I understand that telephone or video conferencing technology will be used for our consultations and will not be the same as traditional direct patient to 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 or I can discontinue the telemedicine consult/visit if it is felt that the connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and payment purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider if needed to operate equipment. If others are present other than my provider they will maintain confidentiality of the information obtained. I further understand that I will be informed of anyone else presence and may refuse to have the consultation or may have the right to omit details.

5. I know that I have alternatives to telemedicine such as choosing a physician who engages in traditional office visits. 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.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise me to be seen by my local practitioner or emergency room and that the specialist's responsibility will conclude upon the termination of the telephone or video conference consultation

7. I understand that payment is due at the time services are rendered and that Advance Health Integrative Medicine does not work with insurance and services are cash pay.

8. I understand that if I have any further questions that may arise with regard to these consultations I can have a conversation with my doctor or representative during which I can discuss any concerns. My questions have been answered and I understand any risks, benefits and any practical alternatives. 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 ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time