Informed Consent for Telehealth Consultations

Patient Name: ______________________ **Date of Birth:** ______________

Referring Provider Name: ______________ **Date Discussed:** ______________

Consultant Name: ______________________ **Specialty:** ______________

To better serve the needs of CHCNC patients, services are available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care diagnoses. This process is referred as "telemedicine" or "telehealth". This means that you may be evaluated and treated by a health care provider or specialist from a distant location. Since this may be different than the type of consultation which you are familiar, it is important that you understand and agree to the following statements.

I understand that:

1. **I can withdraw consent for telehealth services at any point during the process. Further, I understand that refusal to participate in the telehealth program will not affect the right to future care or treatment.**
2. **My health care provider, CHCNC, has recommended for me to engage in services via telemedicine.**
3. **My health care provider has explained to me how the telemedicine technology will be used to affect such a encounter.**
4. **There are potential risks to this technology, including interruptions, and technical difficulties. I understand that my health care provider and/or a representative of my health care provider or I can discontinue the telemedicine encounter if it is felt that the interpretations and/or technical difficulties are affecting the quality of encounter.**
5. **I will be informed of any additional personnel are to be present other than myself, individuals accompanying me, my health care provider or a representative of my health care provider and via video, and give my verbal permission prior to entry of any additional personnel.**
6. **My health care provider for whom the on-site examination or treatment is performed will keep a record of the encounter in my medical record.**
7. **I voluntarily consent to health care services provided by my health care provider or a**

designee, which may include diagnostic tests, medication, examination and treatment considered necessary to treat my health problem.

8. I may access my medical records including those generated via a telehealth visit in accordance with the Health Insurance Privacy and Portability Act requirements as well as any other federal, state, and local regulations.
9. I authorize payment directly to CHCNC for all benefits payable by my insurance carrier.
10. While I may benefit from telehealth services, results are not guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, have discussed it with my medical/dental provider or their assistants as designated, and any questions that I had have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical/dental care.

_______________________________ _______________________________

Patient Signature Date

_______________________________ _______________________________

Referring Provider Signature Date

I have been offered a copy of this consent form for my records: _________________ (patient initial)