DGMA TELEVISIT CONSENT FORM

DATE: _____________

PATIENT: __________________________ FACILITY: _______________________________

Informed Consent for Telemedicine Services

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation and will not be the same as a direct patient/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 videoconferencing connections are not adequate for this 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 consultation other than my health care provider and consulting health care 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.

____ Accept (marked by patient or facility staff on behalf of the patient in the patient's presence, indicating explanation of requirements, understanding and acceptance of medical services being rendered electronically).

____ Decline

Patient Name – OR – Representative, if pt. unable to sign:____

Signature:____