CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION/SERVICES

Date of Service: _____ Staff: _____

Patient's Name: _____ Date of birth: _____

Telemedicine services involve the use of secure interactive video conferencing/audio conferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that I am willingly and freely engaging in a telemedicine consultation with a healthcare professional from OneCare Health- Advanced Practice Health and Wellness Corp.
2. My health care provider has explained to me how the video conferencing technology will be used to execute such a consultation. I understand that this consultation 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(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing 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 consultation other than my health care provider and consulting health care provider in order to operate the video equipment and translate in an event there is a language barrier. 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 voluntarily and willingly chose this service knowing the alternatives to a telemedicine consultation and in choosing to participate in a telemedicine consultation, 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. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented. I understand that I will be responsible for any out-of-pocket costs such as copayments, fees or coinsurances that apply to my telemedicine visit. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that it is required to record all telehealth visits either audio or both video/audio for compliance, billing, legal and any auditing due diligence.
8. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
9. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine services. I understand that my insurance carrier will have access to my medical records for quality review/audit.
10. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) I am located in the state of NY, NJ, or FL and will be in these states during my telemedicine visit(s). (3) Providers who are licensed hold licenses in NY, NJ and FL only.

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature