GASTROENTEROLOGY AND HEPATOLOGY CENTER
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TELEMEDICINE CONSENT FORM

- I understand that **telemedicine** is the use of electronic information and communication technology by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider.
- I understand my healthcare provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter.
- I understand I can choose to stop the telemedicine consult at any time.
- I understand that my healthcare professional and I will communicate by interactive video conferencing using a telehealth platform.
- I understand that the physical examination part of the office visit will be significantly limited due to the video conversation.
- I understand my healthcare professional will have access to all the clinical tools available at a regular office visit (e.g. prescription refills, appointment scheduling, patient education etc.) and the telemedicine encounter will be documented in the patient's medical records just like any other office visit.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties, I understand that my healthcare provider's practice is not responsible for any violation of internet privacy and that my healthcare provider's practice will do it's best to ensure HIPAA compliance but it is not a guarantee since the consult/visit is done over the internet.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes and as always my insurance carrier will have access to my medical records for quality review/audit.
- I understand that I am responsible for the copay (for a specialist office visit) and any balances not covered by my insurance company. These balances include any deductibles, co-insurance, or insurance rejections. The telemedicine visit will be submitted by the practice to my insurance company first before I am billed. Once the practice receives an Explanation of Benefits, then I will be billed for any potential financial responsibility indicated by my insurance plan.

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 it's contents including the risks and benefits of this form of communication.
That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
That I will not hold the practice (Sanjeev M. Wasan M.D. PLC, Gastroenterology & Hepatology Center) in any liability regarding the use of the telehealth platform, the internet browsers and the telemedicine provider consultation/visit.

PRINT PATIENT NAME: _____ DATE:_____

PATIENT SIGNATURE: _____