Mind & Peace Connection Center

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Informed Consent for Telemedicine/Telehealth Services

Patient Name________________________________Date of birth ______________

Location of patient____

Physician/therapist name___________________________Location ________________

Consultant name_________________________________Location ________________

Introduction:

Telemedicine/telehealth involves the use of electronic communication to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Laboratory tests
- Live two-way audio and video

Expected benefits:

- Improved access to medical care, psychiatric services, psychotherapy, and/or counseling.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine/telehealth services. These risks include, but may not be limited to:

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Please initial after reading this page: ______

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/telehealth services, and that no information obtained in the use of telemedicine/telehealth services which identifies me will disclosed to other entities without my consent.
2. I understand that I have the rights to withhold or withdraw my consent to the use of telemedicine/telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine/telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical/health care may be available to me, and that I may choose one or more of these at any time. My doctor/therapist has explained the alternatives to my satisfaction.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
6. I understand that insurance coverage of telehealth sessions may differ based on my insurance plan. It is in my best interest to check with my insurance company regarding the coverage.
7. I understand that I am fully responsible for co-payments and deductible amounts, and that I am fully responsible to pay the provider if telehealth/telemedicine sessions are not covered by my insurance company.

Patient Consent to the Use of Telehealth/Telemedicine Services

I have read and understand the information provided above regarding telehealth/telemedicine services, have discussed it with my physician/therapist, and all of my questions have been answered to my satisfaction. I hereby give consent for the use of telehealth/telemedicine services in my care.

I hereby authorize Asim Rana MD P.C. to use telehealth/telemedicine services in the course of my diagnosis and treatment.

Signature of patient (or person authorized to sign for the patient):

____ *Date:* _____________

If authorized signer, relationship to patient: _______________________________

*Witness*______________________________________*Date* ________________

I have been offered a copy of this consent form (patient's initials): _______