LOUDOUN MEDICAL GROUP PC

CONSENT TO PARTICIPATE IN TELEMEDICINE

Patient Name:_____ Date of Birth: _____

Physician Name: _____ Facility Name: _____

I understand that telemedicine is the use of electronic information and communication technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand my health care 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 telemedicine consult at any time.

I understand that:

- My health care professional and I will communicate by interactive video conferencing using a telehealth platform.
- My health care professional will have access to all the clinical tools available at a regular office visit. (e.g. prescription refills, appointment scheduling, patient education etc.)
- The Telehealth platform may ask for vital signs. I understand I will enter height in feet and inches, weight in pounds, blood pressure, temperature, and pulse rate.
- There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.
- The laws that protect privacy and the confidentiality of medical information also applies to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

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 its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date

Updated: 03/17/2020