CONSENT FOR TELEMEDICINE SERVICE AND AGREEMENT

I am a patient of Addiction Care of Excellence (ACE) established by a face-to-face visit with my healthcare providers at ACE (ACE providers) in an office of ACE.

In addition to face-to-face visit in an office of ACE, I also request my ACE providers to render care by using the video conferencing technology (telemedicine). I fully understand the following:

- A telemedicine visit is different from an office face-to-face visit. I will be seeing and talking to my ACE provider via a video conferencing device, such as a computer or a smart phone. Physical examination may be limited at a telemedicine visit. I do have the option of receiving care from my ACE provider face to face in an ACE office.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my ACE provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the telemedicine visit other than my health care provider and consulting health care provider in order to facilitate the visit.
- The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the telemedicine visit 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.
- In an emergent consultation, I understand that the responsibility of my ACE providers is to advise my options and that their responsibility will conclude upon the termination of the video conference connection.

The fee for a telemedicine visit is the same as the fee for an equivalent office visit. I agree to pay for my care at the time when the care is rendered. Unless other means of payment is secured, I agree to keep with ACE a notarized credit card authorization.

I understand that I am fully responsible for the service charges. ACE does not bill my insurance for telemedicine service. I may continue to come to ACE office to receive care and authorize ACE to bill my insurance for the office visit.

If drug testing is mandatory, I agree to complete the required test in an ACE office within 3 days before the scheduled telemedicine visit.

If a supervised medication administration is mandatory, I agree to bring my medication to an ACE office and take the medication under the direct supervision of an ACE staff within 3 days before the scheduled telemedicine visit.

I request my ACE provider to prescribe my medications, including controlled substances, to the pharmacy of my choice. I understand if electronic prescriptions cannot be delivered to my pharmacy for whatever reasons, I will pick up my written and signed prescriptions in an ACE office or have my prescriptions mailed to me. I understand delay may occur and my treatment may be interrupted as a result.

I have had a direct conversation with my ACE provider, during which I had the opportunity to ask questions in regard to the ACE telemedicine services. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

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 ACE telemedicine
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction
- That I have the right to terminate this agreement without cause at any time in writing

Patient:	**Patient's Representative and/or Caregiver (if applicable)**
Signature:_____	Signature:_____
Print Name: _____	Print Name:_____
Date: _____	Date: _____