Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable patients to have access to their primary care physician remotely. The information may be used for diagnosis, therapy, follow-up and/ or education. In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician and consultant(s); In these instances, an in-person visit will be recommended.

Please complete and sign the below consent agreement so we may provide telemedicine services to you. Please list all patients on your account.

Name:_____DOB:_____Name:_____DOB:_____

Name:_____DOB:_____Name:_____DOB:_____

Please make every effort to ensure you are in a quiet and private environment when conducting a telemedicine so the best quality of care can be given

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, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time with out affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me and that I may choose one or more of these at any time.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. BCD Health Partners Financial Policy applies to telemedicine visits. Payment of copays, deductibles or any service deemed as patient responsibility by your insurance provider will be charged.

Patient/Guardian consent to use of telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize BBCD Health Partners to utilize telemedicine as a resource for providing appropriate care.

Signature of Patient/Guardian:_____Date:_____