



Where Your Healing Begins

Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers to connect with patients using interactive, live two-way video and audio communications. Through the use of telemedicine, providers can evaluate, diagnose, treat and refer patients as needed.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care
- Ability to receive medical evaluation and care management (when appropriate) without the need for a face-to-face visit.

Possible Risks:

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

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- 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;

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, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and documented in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. 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. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

	Phone Number	Address	Business Hours
Livingston	936-327-1055	309 Hwy 59 S Loop	Monday – Friday: 8.00 AM – 5.00 PM
Cleveland	281-592-9775	108 S William Barnett Ave	Saturday – Sunday: Closed

6. I understand that some medical conditions need to be evaluated in a face to face exam. If it becomes clear that the telemedicine encounter is unable to provide all the clinical information needed, I also understand that my provider will advise me to come in for a face to face evaluation.
7. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
8. 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.
9. I understand that in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care by contacting the office and/or my provider.
10. In cases of emergency, DO NOT USE Telemedicine. Instead, call 911 immediately.

Payment for Telemedicine Services

Calvary Medical will bill insurance for telemedicine services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telemedicine, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. Information regarding the prompt pay is available at our front desk.

We will provide you with a statement of service to submit to your insurance company if you wish.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider and all of 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 Calvary Medical and/or Calvary Urgent Care to use Telemedicine in the course of my diagnosis and treatment.

Signature of Patient: _____ Date: _____

Printed name: _____

or

Authorized Representative: _____ Date: _____

Printed Name: _____

Relationship to patient: _____

Witness: _____ Date: _____

Printed Name: _____