



Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. Nature of telemedicine services. During the telemedicine consultation:
 - a) This is a live 2 way audio and video involving the use of electronic communications to enable health care providers to continue to provide medical care
 - b) Details of your medical history, examinations, lab, diagnostic results and any other necessary medical problems may be discussed as in a regular visit.
2. Expected Benefits:
 - a) Improved access to medical care by enabling patient to remain at his/her remote site while
 - b) Avoid urgent cares and emergency room if not needed
 - c) Access healthcare 24 hours a day, 7 days a week.
1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
 - a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
 - a. I may revoke my right at any time by contacting NW Cypress Pediatrics and Family Medicine at 281-469-7400
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
 - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
 - c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	DOB	Patient/Parent/Guardian Signature

Other patient minors associated with guardian	DOB