Neurology Specialists of the Treasure Coast, P.A.
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Board Certified in Neurology

PATIENT CONSENT FOR TELEMEDICINE

Patient Name:_____ Date:_____

Introduction: Telemedicine involves the use of real-time audio, video or other electronic media communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, and follow-up. During your telemedicine consultation, details of your medical history and personal health information may be discussed through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place.

Risks, benefits and alternatives: The benefits of telemedicine include having access to medical specialists and additional medical information without having to travel outside of your home. The potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face–to–face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols may fail causing a breach of patient privacy. The alternative to telemedicine consultation is the face–to–face visit with a physician.

Confidentiality: All existing confidentiality protections under federal and state law apply to information use or disclose during your telemedicine consultation.

My rights: I understand that I have the right to withhold or withdraw my concern for the use of telemedicine at any time during the course of my care, and withdrawal of my consent will not affect any future care or treatment from my doctor. I understand that my doctor has a right to withhold or withdraw his consent for the use of telemedicine at any time during the course of my care.

My responsibilities: I understand that I must be physically within Florida to be eligible for telemedicine. I understand that the healthcare services rendered may not be covered by or may indeed exceed my plan benefits, and I am financially responsible for all of the cost that is associated.

I will ensure the proper configuration and functioning of all my electronic equipment prior to my session because a computer, tablet, or mobile telephone I use must-have working camera and audio input so my doctor can see and hear me in real time.

I will not record any telemedicine sessions without written consent from Neurology Specialists of the Treasure Coast, PA, and I understand that my doctor will not record any of our telemedicine sessions without my consent.

My healthcare provider has discussed with me the information provided about. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have agreed to a telemedicine consultation.

Patient Signature: _____ Date:_____

Witness Signature:_____ Date:_____

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