Now Serving Wentzville, Rolla, & Creve Coeur
P# (314) 991-2013 F# (314) 991-2006

I @FirstName @LastName agree to participate in a telemedicine evaluation. Telehealth is the use of electronic information and telecommunications to support and promote long distance clinical healthcare.

I understand that during this evaluation, my provider will evaluate and treat my medical condition as they would in the office. During the telemedicine evaluation my doctor may:

- Discuss details of my medical history, tests, radiology results and examinations
- Conduct a physical examination through the use of interactive video, audio, and telecommunication technology.
- Have a medical assistant or technologist present for all or part of the visit
- Take video, audio and or photos during the visit if appropriate

I understand that all existing laws regarding access to medical information and copies of my medical records apply to this telemedicine consultation. Please note: not all telecommunications are recorded.

I understand that reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections apply to information disclosed during this telemedicine consultation.

I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical care.

I understand that I can withdraw my permission to receive telehealth at any time and do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. If I do not choose to participate in a telemedicine session, I understand that no action will be taken against me that will cause a delay in my care and that I may pursue face to face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee therefore this telemedicine session will eliminate the need for me to see a provider in person.

I understand that my provider will submit a bill to my medical insurance carrier for this telehealth visit. I understand that I am financially responsible to the practice for any amounts due that are not covered by my insurance policy. I agree to pay all charges for services rendered by the practice during my telehealth visit.

☐ I have read this form and understand the risks and benefits of the telehealth visit. I agree to a telehealth visit under the terms explained above. I consent to receive healthcare services via telemedicine.

Signature: _____

DATE: @Today