



SURGICAL DERMATOLOGY ASSOCIATES DENTON, P.A.

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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. 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 the 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 Surgical Dermatology Associates at 940-591-0900.
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 responsible for any out-of-pocket costs such as copayments, deductibles 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.
8. I understand that although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failure of security safeguards or illegal and improper tampering.

Waiver/Release. 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

Patient/Parent/Guardian Signature

Witness Signature

Date

Patient Compliant Procedure:

While we hope that every patient's visit goes smoothly, it is important that we are notified of patient concerns so that we can address them. If you have comments, questions, or concerns, we recommend that you or your representative discuss them with your immediate caregiver or speak to the office manager. Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants may be reported for investigation at the following address: Texas Medical Board of Investigations, 333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263 Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following number: 1-800-201-9353. For more information, please visit the website at www.tmb.state.tx.us