FLATIRON
ALLERGY & ASTHMA
CENTER

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Name: _____ Date of Birth _____ Today's Date/Time_____

Telemedicine Consent:

Introduction:
Telemedicine involves the use of electronic communications to enable health care providers at different locations to communicate with patients for the purpose of improving patient care. Providers may include primary care practitioners and specialists.
The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

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 by enabling patients to remotely contact their medical provider.
- More efficient medical evaluation and management

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:

- Information transmitted may not be sufficient (e.g. poor resolution of images, lack of in person physical exam, vitals, and other procedures such as spirometry) 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
- Security protocols can fail, causing a breach of privacy of personal medical information
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors

Initial: _____

By signing this form, I understand the following:

1. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider will not be able to perform a complete physical examination; this includes inability to obtain vital signs; use an otoscope to visualize eyes, ears, nose and mouth; use a stethoscope to listen to the lungs and heart; this also includes inability to complete testing including spirometry and exhaled nitric oxide testing as well as allergy skin testing.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
4. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the specialty healthcare provider or the primary care provider.
5. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as the emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.
6. Cost: I understand that the telemedicine visit will be billed through insurance. If it is not covered by insurance, I may be responsible for the cost which may range from 115 and 225 dollars.
7. 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.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, 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.

_____ _____

Patient or Guardian Date