NON-SURGICAL ORTHOPAEDICS, P.C.
Specializing in Spine Care & Pain Management

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Informed Consent for Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers to provide patient care remotely in the event a patient is not able to travel to the medical office for their medical care. The information during this telemedicine encounter may be used for diagnosis, therapy, follow up, treatment, medication management and patient education. Electronic systems used will incorporate network and software security protools to protect the confidentiality of protected healthcare information. In addition it will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Possible Risks:

There are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician or nurse practitioner.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information (PHI).
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions, allergic reaction and other judgement errors.

By signing this form, I understand the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that telemedicine may involve electronic communication of my personal medical information to / from other medical practitioners who may be located in other areas, including out of state.
- I understand I need to start the check in process of my telemedicine visit 30-60 minutes prior to my appt. time depending on whether I am a new or existing patient. Instructions will be provided.

- As documented in the financial policy I understand that all my financial responsibilities as the patient will be due prior to my telemedicine visit. These fees will be collected over the phone via a credit or debit card. Any denied charges for any reason or amounts due not collected are my financial responsibility.
- I agree I am requesting this service and that once this service is documented in my medical records, I will not dispute this charge or other charges associated with my telemedicine encounter. I am verifying the service was received and all medical service charges to my credit or debit card were received. I waive my right to dispute these charges with my credit card company and / financial institution.
- I understand that it is my duty to inform my doctor or nurse practitioner of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand the risks and 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.

I hereby authorize Non-Surgical Orthopaedics, P.C. to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____

If authorized signer, relationship to patient: _____

Date: _____