Informed Consent for Telemedicine Service

PATIENT NAME:____________________________	**DOB:__________**
CLINIC LOCATION:____________________	**MRN:_________**

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Allergy & ENT Associates providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I authorize for a credit card payment to be securely stored and payment in full deducted when a telemedicine visit has occurred.

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 of treatment. I may revoke my consent orally or in writing at any time by contacting Allergy & ENT Associates. As long as this consent is in force (has not been revoked) Allergy & ENT Associates may provide health care services to me via telemedicine without the need for me to sign another consent.

Only two virtual visits will be scheduled per calendar year and will not replace annual face to face visits.

*****Computer or Cell phone must have audio and visual capability******

_________________________________ ___________________________
Name (Parent or Guardian) Please Print Signature

____________________________________ _____________________________
Witness Date