Telemedicine Informed Consent

Patient Name:	Last	MI	First	DOB
Patient's Location during telemedicine visit:				
Provider Seeing Patient During Telehealth Visit:			Provide Location: 45 Cavalier Blvd. Florence, KY 41042	

- I understand that I or my child will have a telemedicine appointment which may include videoconferencing technology, video or still (high quality photo) images, or telephone conferencing. During videoconferencing, I/my child will be able to see and hear the provider and he/she will be able to see and hear me/my child.

- I understand that a telemedicine appointment can improve access to care by enabling me/my child to remain at home and obtain services from a distant location

- I understand that if I am not comfortable with seeing a provider on videoconference technology, I may reject the use of the technology and schedule a traditional face-to-face encounter at any time. I understand that safety measures are being used to ensure that this videoconference is secure, and no part of the encounter will be recorded without my written consent.

- I understand that there are potential risks associated with the use of telemedicine which include, but may not be limited to:
    - A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
    - Technology problems may delay medical evaluation and treatment for today's encounter.
    - In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information, I understand that I will be promptly notified if any security issues arise.

By Signing this Form, I understand the following:

- I have the right to 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.
- If the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time, stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit with the provider.
- I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- The laws that protect privacy and confidentiality of medical information also apply to telemedicine.
- I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the providers at Alexius M. Bishop, M.D., P.S.C. to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or authorized person)	Date/Time
If authorized signer, relationship to patient	
Witness Date/Time	