Patient Informed Consent for Telemedicine Services (Continued)

By signing below, you acknowledge that you understand and agree with the following explanation of "Informed Consent"

1. 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 written consent.
2. 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.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and I'm choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed assured.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare providers order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

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 my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits of the teleconferencing consultation and a telemedicine visit under the terms described herein.
By signing below, I hereby state that I have read, understood, and agree to the terms of this document.

☐ If Medicaid is your primary insurance, Telemedicine Services are an uncovered benefit please check box to op-out.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Legacy Authorized Representative/Relationship Date