Informed Consent for Telemedicine Services

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Name: **Montgomery Gynecology LLC**

Location: 115 Plymouth Road, Plymouth meeting, PA 19462

 **Introduction to Virtual visits**:

Virtual visit is a way physicians provide convenient healthcare access for the patients through secure real time face to face video visits. This specific HIPPA compliant platform may be used by your women’s healthcare provider for reviewing the results, minor diagnoses which doesn’t require detailed exam, monitoring treatment plans, post op follow ups, family planning and pre-conception care etc.

 Electronic medical record systems used will incorporate network and software security protocols to protect the confidentiality of patient identification, lab 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 a patient to remain in her original location.

Saved time by avoiding traffic and parking.

Saved money by no time off from work or paying for sitter

**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:

In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician.

Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment or need for a physical exam

In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to virtual visits, and that no information obtained in the use of virtual visit which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of virtual visits in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time

4. I understand that virtual visit services at this time are not reimbursed by payers in Pennsylvania and I am **responsible for the full payment of the visit at the time of the visit**. I am aware of the full price of the visit at the time of signing of this consent, provided by the receptionist.

5. I understand that physician may recommend office visit for physical exam after a virtual visit based on the initial evaluation. I understand that I am still responsible for full payment of the virtual visit.

 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.

I have read and understand the information provided above regarding Virtual visit, 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 Montgomery Gynecology LLC to use telemedicine in the course of my medical care.

Signature of Patient: Date:

Witness: Date:

I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_