Telemedicine Consent Form

CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS

I understand the purpose for this service is to seek medical advice and guidance for my care, and I do not have an emergency condition. I also understand that at any time if I feel I cannot wait for a visit or feel my condition has become an emergency then I will call 911 and/or seek emergent care.

I understand that telemedicine is the use of video communication or telecommunication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell or use certain physical exam modalities in assessing my condition.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment, but there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment.
- Delay in care resulting from communication service or equipment failure.
- Inadequate visual resolution resulting in incomplete assessment.
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse event.

In addition to these risks, I understand that the remote provider evaluating me does not have the opportunity to meet with me in-person and must rely on information provided by me or the on-site provider. I understand and acknowledge that the remote provider cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges for my telemedicine visit. I understand that my telemedicine visit may not be covered by my insurance plan.

I have had the opportunity to review this information prior to any form of payment being collected. By signing YES on the intake form, I indicate that I have chosen to proceed with the telemedicine visit.

I understand that the remote provider is a provider at Lung Care &. Lung Care & will maintain a record of this telemedicine visit and I may obtain a copy of that record as provided in the Notice of Privacy Practices.

I consent to the healthcare provider I am connected with providing healthcare services to me via telemedicine. As long as this consent has not been revoked by me, it remains in effect. The physician may provide healthcare services to me via telemedicine pursuant to this consent without the need for me to sign another consent form.

By circling YES to the TELEMEDICINE question on my intake form, I consent to this medical treatment.

**Form 06012024