RADIANT DERMATOLOGY

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CONSENT TO PARTICIPATE IN TELEMEDICINE

Patient Name:_____ Date of Birth:_____

Physician Name: Dr. Amanda Friedrichs

I understand that telemedicine is the use of electronic information and communication technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand my health care provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. I understand I can choose to stop the telemedicine consult at any time. **Due to the rapidly evolving reimbursement guidelines during the COVID-19 outbreak, I understand that I will be charged my copay amount or $75 fee for the visit, which will be refunded if and when my insurance company covers the cost of the visit.**

I understand that:

- My health care professional and I will communicate by interactive video conferencing.
- My health care professional will have access to all the clinical tools available at a regular office visit. (i.e. prescription refills, appointment scheduling, patient education, etc.)
- There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- My healthcare information may be shared with other individuals for scheduling and billing purposes.
- 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.

By signing this form (or via verbal consent if signing not possible), I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date

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