



## Faith Home Care Practitioners, PLLC

34 NE Boistfort St. Ste. 123, Chehalis, WA 98532

### Authorization and Consent for Telemedicine Visit

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. I understand that my health care provider wishes me to engage in a telemedicine visit, which is a two-way conferencing platform that uses audio and video to communicate and transmit your health care information in order to delivery medical care in place of a home or office visit.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. 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 health care provider in 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.
5. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
6. I understand that billing will occur from my practitioner and will be billed directly to my insurance. I will be responsible for any copays or deductibles.
7. 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 of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

By signing this form, 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 any questions have been answered to my satisfaction.

\_\_\_\_\_  
Patient's/parent/guardian signature

\_\_\_\_\_  
Date