Rocky Mountain Neurology Telemedicine Informed Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials

_____ I understand that telehealth involves the communication of my medical information in an electronic or technology-assisted format.

_____ I accept that I authorize to Dr. Barrett, Dr. Kitei, Dr. Coerver, or Dr. Elgavish to use telehealth for my diagnosis and treatment.

_____ I accept that I need access to a mobile device and a good internet connection in order to have an efficient telemedicine appointment.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Colorado at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage. I understand that I can be charged any additional fees that my insurance does not cover.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ I agree that the healthcare provider is not responsible for breaches of confidentiality caused by me or by an independent third party.

____ I agree that information exchanged during my telehealth visit will be maintained by the doctor, other healthcare providers, and healthcare facilities involved in my care.

____ I agree that I will verify to my healthcare provider my identity and current location in connection with the telehealth services.

____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, or an in-office visit if needed.

____ I understand that my healthcare provider may choose to forward my information to an authorized third party or communicate clinical information to me through email. Therefore, I have informed the healthcare provider if there is any information I do not wish to be transmitted through electronic communications.

____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

My most reliable contact information for telehealth communication:

Phone number: _____

Email: _____

I certify that I have read and understand this agreement with the opportunity to have questions answered to my satisfaction.

For electronic communication between Dr. Barrett, Dr. Kitei, Dr. Coerver, Dr. Elgavish

Rocky Mountain Neurology staff and _____

(Patient's name)

_____ _____

Patient or Legal Representative Signature | Date

_____ _____

Print Patient or Legal Representative Name | Relationship to Patient (if other than self)