Tri-MED Telemedicine Authorization Form

Patient Name: _____ DOB _____

1. PURPOSE: I understand that the purpose of this form is to obtain my consent to engage in a telemedicine consultation with my healthcare provider (s).

2. NATURE OF SERVICE: I acknowledge that my healthcare provider(s) or their representative has explained to me how the video conferencing technology will be used. I understand and accept that I will not be in the same room as my healthcare provider. I understand that there are potential risks due to the nature of telephone/videoconferencing technology, including interruptions, unauthorized access and technical difficulties.

3. RIGHTS: I understand that my healthcare provider or I can discontinue the telemedicine visit at any time.

4. CONFIDENTIALITY: 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 healthcare provider and consulting healthcare 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: (a) omit specific details of my medical history/ condition that are personally sensitive to me; (b) ask non-medical personnel to leave the telemedicine examination room: and or (c) terminate the consultation at any time.

5. MISCELLANEOUS: I have had the alternatives to a telemedicine consultation explained to me, and I am choosing to participate in a telemedicine consultation. I understand that some parts of my visit/exam, particularly those involving physical examinations, may be conducted by others, including my provider's supporting staff, at the direction of my provider. Some medical data such as my last known weight, review of prescriptions/ pharmacies, current contact information, insurance, and other relevant medical information may be obtained verbally by my healthcare provider or supporting staff, at the direction of the healthcare provider.

6. EMERGENT CONSULTATIONS: In an emergent consultation, I understand that the responsibility of the telemedicine provider is to advise me to call 911 or proceed to my local emergency room. My telemedicine provider's responsibility will conclude upon the termination of the phone call/ video conference connection

7. PAYMENT OF SERVICES: I understand that billing will occur from Tri-MED's offices. If I have insurance, my insurance will be billed. I am responsible for any patient portion not paid by my insurance.

8. DISPUTES: I agree that any disputes that arise from my telemedicine consult will be resolved in Texas and Texas State Law shall apply to all disputes.

By signing this form, I certify:

- That I have read this form and fully understand its contents including the potential risks and benefits of the telemedicine visit(s).
- I have had a direct conversation with my provider or a supporting staff member from Tri-MED, during which I had the opportunity to ask questions in regards to this telemedicine visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

_____ _____

PATIENT'S SIGNATURE/ GUARDIAN SIGNATURE DATE