PULMONOLOGY ASSOCIATES, INC TELEMEDICINE INFORMED CONSENT FORM

Patient Name: _____ DOB: _____

1. Telemedicine is a service that uses technology to provide health services from a distance without having to meet in-person at an office. Patients may benefit from telemedicine, but just with any other professional service, results cannot be guaranteed or assured. Benefits include improved access to services and reductions of barriers by enabling patients to remain at remote site while the healthcare professional provides care elsewhere, more efficient coordination and management of services. Obtaining the expertise of a distant specialists not available locally. I agree to engage in a telemedicine consultation/visit.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation/visit 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 visit other than my health care provider and consulting 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/visit 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. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine visit. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation/visit, 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.

7. I understand that billing will occur from both my practitioner all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. **Non-covered services: Please be aware that these services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay for these services in full if not covered by insurance.**

8. I have received this consent form, during which I had the opportunity to ask questions in regard to telemedicine. I understand the risks, benefits and any practical alternatives.

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