PEARL HEALTH CLINIC
2705 E 17TH ST.
Ammon, ID 83406
Phone: 208.346.7500
Fax: 208.346.7501

Telehealth/Medicine Informed Consent

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the videoconferencing technology will be used and that such a consultation will not be the same as a direct patient/healthcare 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.

4. I understand that my health care 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 and consulting healthcare provider in order to operate the video equipment. The above-mentioned individuals and staff members 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. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in telemedicine consultation; 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 healthcare provider.

6. In an emergent consultation, I understand the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist responsibility will conclude upon the termination of the videoconference connection.

7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. 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.

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8. I also understand that the initial evaluation for the policies of the clinic will be a face-to-face consultation, unless extenuating circumstances require a telemedicine initial consultation.

9. I also understand that in any time I can request from my healthcare provider to change my visits to face-to-face if I desire.

10. My provider has explained to me that the telemedicine system being utilized is a HIPAA compliant and the technological requirements in order to participate in utilizing the system have been explained to me and I also understand that I have the equipment and technology to participate efficiently in the evaluation.

    By signing this form, I certify;

    I have read or had this form read and/or at this form explained to me that I fully understand its contents including the risk and benefits of the procedure (s).

    I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

    Patient/Parent's Email Address (please print and include whether case sensitive)

    _____

    Patient's Name (Printed): _____ **Date:** _____

    Signed: _____

    Guardian's Name (Printed): _____ **Date:** _____

    Signed: _____