Coastal Carolina Neuropsychiatric Center

Telemedicine Consent Form

This form is intended to provide information about telemedicine visits, which are different from in-person office visits and require separate consent from the patient.

1. Telemedicine uses audio and video technology to enable health care providers to have visits in real time with patients who are not physically present in the office.
2. During a telemedicine visit, the information obtained, such as medical history, examinations, diagnostic imaging, and/or test results will be used for diagnosis, treatment, follow-up, and/or education. I understand tests may be conducted by individuals at my location at the direction of the telemedicine provider. Communication will be through live two-way audio and video, so that the patient can talk with the provider.
3. Consenting to receive telemedicine visits does not mean that all future visits will be via telemedicine.
4. The provider has the right to determine whether or not any given patient visit is appropriate to be conducted via telemedicine. The provider and the patient both have the right to discontinue the visit at any time.
5. The records of telemedicine visits will become part of the patient's medical record. All existing laws regarding your access to medical information and records apply to telemedicine visits. Sharing of any personal health information to other persons or entities outside of ***Coastal Carolina Neuropsychiatric Center's*** providers and staff shall not occur without the patient's written consent unless shared for purposes of treatment, practice operations, or billing.
6. There are technology related risks in using telemedicine, such as problems with transmission (such as low resolution or interruption in the signal) and/or deficiencies or failure of telecommunications equipment. These may interfere with proper evaluation of the patient. In addition, the transmission is encrypted, and other measures have been taken to prevent unauthorized parties from accessing the transmitted information.
7. Please protect your email and patient portal passwords, and notify the practice of changes of email address.
8. This telemedicine visit will follow the same process for billing and payment for an in-person, face-to-face visit and the patient or subscriber may be responsible for all or some of the bill based on insurance coverage.

Consent To The Use of Telemedicine

I have read and understood the information provided above regarding telemedicine, including the risks associated with online communication, and all of my questions about telemedicine have been answered to my satisfaction. I give my consent for the use of telemedicine for my care at ***Coastal Carolina Neuropsychiatric Center, PA***.

Signature: _____ Date of Birth: _____
Patient (or person **legally** authorized to give consent on patient's behalf)

Printed Name: _____ Date: _____

Relationship to patient: ☐ Self ☐ Parent/Legal Guardian (*for children under age of 18*)