Telehealth- Patient Consent Form

Patient Name:_Date of Birth:

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the providers at Laramie Physicians Women & Wellness Clinic (LPWWC) to provide health care services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, my insurance carrier will have access to my medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit. The payment policy as set forth in the FINANCIAL AGREEMENT/ PAYMENT POLICY/ AUTHORIZATION FOR TREATMENT consent form will pertain to all telehealth visits.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the staff at Laramie Physicians Women & Wellness Clinic at 307-745-8991. As long as this consent is in force (has not been revoked) LPWWC may provide health care services to me via telehealth without the need for me to sign another consent form. I understand there are potential risks with this technology:

- The video connection may not work or it may stop working during the consultation
- The video picture or information transmitted may not be clear enough to be useful for the consultation.

The benefits of telehealth are:

- I do not need to travel to the consult location.
- I have access to a specialist through this consultation.

I consent that I agree to all the terms and conditions listed above

Signature of patient (or guardian)____Date:______

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