Chestnut Hill Allergy & Asthma Associates, LLC Informed Consent for Telehealth Services

Patient Name: _____ DOB: _____

About Telemedicine:

Telemedicine involves the use of electronic communication technologies by a health care provider to deliver health care services to a patient when the patient and the provider are at different locations.

I understand the following:

- Telemedicine visits are generally not recorded, and video, audio, or images are not electronically stored. My provider will obtain mu authorization to record if he/she recommends the visit for my record.
- Laws the protect privacy and confidentiality of medical information also apply to telemedicine.
- The provider may bill my health care insurance for telemedicine services, and I will be responsible for any copayments or coinsurances that apply to my telehealth visit.
- I have the right to withdraw my consent to the use of telemedicine during my care at any time, without jeopardizing access to other available services or affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by advising my health care provider. If I do not revoke my consent, my health care provider may provide services to me via telemedicine without the need to sign a consent for each telemedicine encounter.

Benefits: Potential benefits of telemedicine include improved access to health care.

Risks: I understand that there are potential risks associated with the use of technology for telemedicine services, including but not limited to:

- The video connection may not work or may stop working during the telehealth visit.
- The video or sound may not be clear enough to be useful to effectively complete the telehealth visit.
- I may need to reschedule an in-person visit if the health care provider believes the information able to be obtained during the telemedicine visit is not sufficient.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- Security protocols could fail, causing a breach of privacy of personal medical information.

Certification of Patient:		
By signing below, I certify that I have been instructed on accessing telehealth services and have had an opportunity to ask the health care provider all my questions concerning anticipated benefits, and potential risks, and all my questions have been answered to my satisfaction. I hereby consent to having my health care provider provide health care to me via telemedicine and accept any associated risks.		
Patient Signature or Authorized Individual	Date	Time
Printed Name of Authorized Individual	Role	

Certification of Health Care Provider:		
I hereby certify that I have discussed with the individual granting consent, anticipated benefits, potential risks, and additional information described in their consent.		
NOTE: ***If verbal consent is obtained in lieu of the patient's written informed consent, complete the*** **VERBAL CONSENT CERTIFICATION** ***section.***		
Licensed Health Care Provider Signature	Date	Time