TELEMEDICINE
(Excluding E-mail)

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine.

Patient’s Initials

_____ I understand the concept of telemedicine, as well as the particular electronic medium to be used.

_____ I understand that at least two health care providers may be involved, the referring and the consulting providers.

_____ I understand that although there has been great progress made in technology, this telemedicine encounter may still be in the experimental stage.

_____ I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers.

_____ The nature and potential risks of this telemedicine encounter have been explained to me.

_____ I understand that in lieu of this telemedicine encounter, I may seek health care elsewhere where I might have face-to-face contact with the health care provider.

_____ I am aware that my referring provider has verified the credentials of the consulting provider and found all to be in order.

_____ I understand that the telemedicine encounter may be a one time occurrence and that treatment and follow-up will remain the responsibility of my referring provider.

_____ I understand that specific procedures may require additional informed-consent process.

_____ I am aware that there are no guarantees with telemedicine.

_____ The doctor has answered all of my questions.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

_____________________________                               _______________________________
Patient or Legal Representative Signature/Date/Time                                              Relationship to Patient

_____________________________                        _______________________________
Print Patient or Legal Representative Name                                                                         Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient’s legal representative. I have

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This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).
answered all questions fully, and I believe that the **patient/legal representative** (circle one) fully understands what I have explained.

_____________________________

Physician Signature/Date/Time

________ copy given to patient

initial

________ original placed in chart

initial