TELEMEDICINE CONSENT/ TERMS AND CONDITIONS

INTRODUCTION

Telemedicine involves the use of video technology to enable health care providers to evaluate, treat and counsel patients when office visits are not possible due to distance or other factors. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) for a medical visit.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: • In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); • Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; • In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; • In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

RIGHTS/EXPECTATIONS:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, 2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment, 3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee, 4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Dr. Kavirajan has explained the alternatives to my satisfaction. 5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 6. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with Dr. Kavirajan. 7. I have been advised that the fees for services provided through telemedicine are the same as those for similar services conducted in the office.

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SIGNATURE DATE