Ear, Nose & Throat Center, LLP

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Patient Name: _____ DOB: _____

1. I understand that I will engage in a telemedicine consultation.

2. The video conferencing technology used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above mentioned people will all maintain confidentiality of the information obtained.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation

6. I understand that I will be billed for this service and reimbursed if your insurance company covers the visit.

8. I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

· That I have read or had this form read and/or had this form explained to me

· That I fully understand its contents including the risks and benefits of telecommunication.

_____ _____ _____
Patient's/parent/guardian signature Date Time