# INFORMED CONSENT FOR TELEHEALTH/TELEMEDICINE

Date:_____

Patient name:_____ Date of birth:_____

**I understand that I have the following rights with respect to telehealth/telemedicine:**

**1. Definition of telehealth/telemedicine.** Telehealth/telemedicine services involve the use of secure interactive videoconferencing equipment and devices or platforms that enable health care providers to deliver healthcare services to patients when located at different sites.

**2. Right to care.** I understand that the same standard of care that applies to an in-person visit will apply to a video visit. I understand that I have the right not to participate or decide to stop participating in a video visit and that my refusal will not affect my right to future care or treatment.

**3. Patient information & confidentiality.** I understand that the laws that protect the privacy and the confidentiality of health care information also apply to telehealth/telemedicine services. I understand that video, audio, or photographs may be stored with my consent, and that I have a right to access my medical information in accordance with federal and state law. I understand that my insurance carrier will have access to my medical information for quality review and/or audit purposes. I understand that I will not be physically in the same room as my clinician and I will be notified of and my consent obtained for anyone other than my clinician present. I understand that the release of my medical information, to include audio and/or video, may be by electronic transmission.

**4. Communication risk & consent.** I understand that there are potential risks with using telehealth and video technology, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, interception, interruption, or distortion due to technical failures. If it is determined, that the electronic connection is not adequate, I understand that my health care provider or I may discontinue use and make other arrangements to continue the visit by other methods. I understand that my consent will be obtained to receive SMS messages to my mobile device according to the Texting Terms and Conditions available at www.wellmedhealthcare.com/texting-terms.

**5. Insurance & Billing.** I agree and understand that I am responsible for any out-of-pocket costs, including deductibles, copayments, or coinsurances, that apply to my video visit. I understand that health plan payment policies for video visits may differ from in-person visits.

**6. Complaints.** I understand that I may file a complaint about physicians, as well as other licensees and registrants of the Texas Medical Board by contacting 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, TX 78768-2018 (attn.: Investigations) or 1-800-201-9353, and more information can be found at www.tmb.state.tx.us.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I understand that I may revoke my consent at any time by contacting my WellMed clinic.

Patient signature:_____ Date:_____

On behalf of patient (family member or caregiver) signature: _____ Date:_____

**Please note:** A guardian or court appointed representative must attach a copy of legal authorization to represent the member.

WellMed does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Please call 888-781-WELL (9355). ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888-781-WELL (9355). 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：888-781-WELL (9355)。

Form is maintained in patient's medical record.