FAMILY PRACTICE CLINIC
200 MULBERRY ST. STE
BOONEVILLE, KY 41314

MT FAMILY PRACTICE CLINIC
90 GARRARD SQUARE
MANCHESTER, KY 40962

FAMILY HEALTH CARE CLI NIC
1012 CENTER DRIVE
RICHMOND, KY 40475

Informed Consent for Telemedicine Services

Patient Name: _____ Date of Birth: _____

Location of patient:_____

Physician Name:_____ Location: _____Date Consent Discussed:_____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to _____ providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I _____agree to receive this health care service (type of service)_____ as a Telehealth service. I understand that the health care provider_____ is located in another facility.

A Telehealth service means that my visit with a practitioner at the distant site will happen by using special audio visual equipment.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care provider in person if I decline the Telehealth service.
- If I decline the Telehealth services, the other options/alternatives available for me including in-person services are as follows: seek alternative providers in your community.
- I understand there is the potential of disruption of electronic communication in the use of Telehealth.
- I understand there will be a facilitator present to make sure that the process is carried out without difficulty and communication will be shared to carry out orders.

- I understand for emergency purposes there may be a need for use of alternative communications. Example: failure of internet services.

If this consent is in force (has not been revoked)_____ may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient (or person authorized to sign for patient):_____
Date: _____

If authorized signer, relationship to patient:
_____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____