ALLERGY & IMMUNOLOGY
MEDICAL CENTER

TELEHEALTH CONSENT FORM (AUDIO or AUDIOVISUAL)

Patient Name: _____

Date of Birth: _____ Patient ID Number: _____

Doctor Name: _____Ojas Patel, MD_____

My doctor or his/her representative has recommended the use of an audio or audiovisual telehealth consultation for my medical condition. He/she has explained to me what will happen during the consultation. I have also been told and given explanation of:

- The risks and benefits of the consultation, including but not limited to:
    - Risks: Incomplete evaluation due to lack of vital signs data, lung function testing or physical examination, and delay in immediate therapeutic intervention with in-clinic medication administration.
    - Benefits: No physical travel required and appointment can be done at patient's residence, and decreased risk of exposure to outdoor allergens and communicable infectious diseases from non-family members.

- The results of not having the consultation, including but not limited to:
    - Lapse in maintaining appropriate medical care including physical evaluation and physical testing resulting in worsening of illness or loss of illness symptom control, and delay in prescription refills due to lack of data as to medication tolerance and benefit.

My signature below indicates:

- I have read and understood the information described in this form.
- I have had a chance to ask questions about the consultation and have received satisfactory answers to my questions.
- I understand that I am giving consent valid for twelve months and that I may withdraw my consent to the consultation at any time for any reason but must provide a written request to do so; this will not change my right to future care or treatment.
- I understand that I will be responsible for any copayments or coinsurances that apply to my audio or audiovisual telemedicine visit. I have been instructed to contact my insurance to confirm the

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coverage for the telehealth services. I am aware that if I do not contact my insurance to confirm coverage for telehealth services or if the telehealth appointment is not covered by my insurance, then I will be responsible for payment of the appointment as an out-of-pocket cost directly to me.

- I understand that all confidentiality protections apply to the telemedicine consultation and that my medical records and medical information are private and confidential to the extent permitted by law.
- I understand that all existing and applicable state and federal laws regarding patient access to medical information and copies apply to this audio or audiovisual telemedicine consultation.
- I understand that there are no guarantees about the results of the audio or audiovisual telemedicine consultation.

_____ _____

Signature of Patient or Legal Guardian Date

If signed by someone other than patient, indicate relationship: _____