

Informed Consent for Telemedicine Services

PATIENT NAME:	
DATE OF BIRTH <mark>:</mark>	
LOCATION OF PATIENT:	
DATE OF SERVICE:	

Information about Telemedicine:

Telemedicine involves the use of electronic communications (telephone, computer, etc.) to enable health care providers (doctors, nurses, physician assistants, and others) at a different location from the patient to share medical information with that patient for the purpose of improving access to patient care. This involves communication of medical information, both orally and visually, to healthcare practitioners located in California.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Images of your face and profile.
- Images of the retina and cornea
- Use of an auto-refractor.
- Use of a lens-meter.
- Comprehensive exam preparation performed by an optical technician.
- Documentation of all testing on patient medical records
- Output data from medical devices and sound and video files. The electronic systems used will attempt to incorporate 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 corruption.

Possible Benefits:

The benefits of receiving telemedicine services have been explained to me. Benefits include, but are not limited to:

- Reduced wait time for appointments.
- Increased convenience.
- Focused healthcare information.
- Improved access to healthcare services and providers.

Possible Risks:

As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but may not be limited to:

• Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye examination



cannot be tested remotely, such as eye dilation. Although it is rare, there may be issues with the resolution quality of images. This may require additional in-person care, which may result in a delayed diagnosis and treatment.

• Although the telemedicine technology uses security safeguards to prevent it, someone could access the telemedicine visit through the interactive connection by electronic tampering.

Do you have epilepsy? YES / NO Other:
Do you experience seizures? YES / NO Other:
PATIENT'S CONSENT:
By signing below, I agree that I have read this document carefully and understand it. I understand that
 My participation in telemedicine is voluntary. Telemedicine visits 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. Arrangements will be made for me to receive in-person services should my provider determine my treatment is not appropriate for a telemedicine visit. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. Individuals may be present to operate the telemedicine technology and all of these individuals must maintain confidentiality of my health care information and may share it only as allowed by law Acuity Optical/Acuity Eye Group maintains my health care and billing records as required by law, and I have the right to inspect and request copies of this information. This includes recordings, images, and other communications related to my telemedicine visit. I will be billed for telemedicine services provided, and if not covered by my insurance, then I will pay for the cost of the exam.
 I have been offered a copy of this informed consent form.
I hereby authorize (name of health care provider) and Acuity Optical/Acuity Eye Group to use telemedicine in the course of my diagnosis and treatment. I understand that this telehealth visits create a provider-patient relationship between me and my provider.
Signature of Patient (or person authorized to sign for patient) Date
If authorized signer, relationship to patient:

Witness

Date