

## Telemedicine Consent

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine.

Patient's  
Initials

- \_\_\_\_\_ I understand the concept of telemedicine, as well as the particular electronic medium to be used.
- \_\_\_\_\_ I understand that at least two health care providers may be involved, the referring and the consulting providers.
- \_\_\_\_\_ I understand that although there has been great progress made in technology, this telemedicine encounter may still be in the experimental stage.
- \_\_\_\_\_ I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the health care providers.
- \_\_\_\_\_ The nature and potential risks of this telemedicine encounter have been explained to me.
- \_\_\_\_\_ I understand that in lieu of this telemedicine encounter, I may seek healthcare elsewhere where I might have face-to-face contact with the health care provider, but in light of the COVID-19 Pandemic there are few of these opportunities.
- \_\_\_\_\_ I am aware that my referring provider has verified the credentials of the consulting provider and found all to be in order.
- \_\_\_\_\_ I understand that the telemedicine encounter may be a one-time occurrence and that treatment and follow-up will remain the responsibility of my referring provider.
- \_\_\_\_\_ I understand that specific procedures may require additional informed-consent process.
- \_\_\_\_\_ I am aware that there are no guarantees with telemedicine.
- \_\_\_\_\_ All of my questions have been answered.

**COMPLAINTS:** Complaints about physicians, physician assistants and nurse practitioners may be reported to the Texas Medical Board. 1-800-201-9353. Website: [www.tmb.state.tx.us](http://www.tmb.state.tx.us)

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to patient (i.e. parent/guardian)

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative (circle one)* fully understands what I have explained.

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Physician Signature/Date/Time

\_\_\_\_ Copy given to patient  
Initial

\_\_\_\_ original placed in chart  
Initial