NAME:_____________________________________ **DOB:**________________________

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

PURPOSE. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician. The purpose of this consultation is to assist in pain management treatment.

Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. **By signing this consent, I understand and agree:**

1. My doctor is located in and licensed by the State of California. My doctor will not be able to prescribe medications for me and will not be able to assist me in any situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services. My doctor may request that I come into the office to submit a random urine sample or bring in medications to count for compliance check.
   INITIALS:_______

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

NAME:________________________________ **DOB:**____________________

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. **FINANCIAL RESPONSIBILITY.** In consideration for the telemedicine services rendered to me. I agree to pay the charges not covered by any insurer or third party payer, including any deductible or co-payment, or any charges not covered as a result of my failure to provide notification authorization for treatment as required by any insurer or third party.
    INITIALS:_______

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telemedicine consultation.

☐ I **AGREE** to participate in telemedicine ☐ I **REFUSE** to participate in telemedicine

____

Signature of Patient or Patient's Representative **Date of Signing**

____

Relationship of Representative to Patient **Name of Interpreter / ID #**

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Signature of Witness (required if patient unable to sign)