DESERT INSTITUTE FOR SPINE CARE

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PATIENT NAME:_____ DATE OF BIRTH:_____

Telemedicine Consent

I authorize my provider at Desert Institute for Spine Care to utilize telemedicine technologies in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occurs in the physical presence of the patient. I will be consulted through audio, video and/or data imaging communications.

Benefits: The reason telemedicine is being utilized is for the following reason(s):

Convenience of encounter for the patient.
Access to healthcare technology not physically readily available.
Need for expertise from a consultant not readily available.
Other

Risks: The reasonably foreseeable risks of utilizing telemedicine technologies may include:

Audio or visual images may not be as good as in person.
Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment or therapy.
Other

Alternatives: The possible alternatives may be:

Travel distance to physically see consultant or undergo the testing/procedure.
Other

Confidentiality: I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to the above named consulting physician either through the mail or transmitted through electronic means as part of telemedicine.

Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above.

PATIENT SIGNATURE:_____ DATE:_____

Please check this box if electronically signed ☐