TELEMEDICINE CONSENT FORM

PEMC of Florida, LLC

Click to fill out Digital form: Telemedicine Consent form

I authorize **Pediatric Endocrine and Metabolic Center of Florida** (PEMC of Florida, LLC) providers to provide me with their observations and recommendations regarding my medical condition and potential courses of action, using telemedicine. The use of telemedicine involves the electronic communication of my medical information. I understand that the provider will not perform an in-person physical examination during the telemedicine consult. They will rely solely on the information telecommunicated by the patient.

I understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.

I understand that the patient MUST be present during the telemedicine visit.

I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit and will adhere to the Office Financial Responsibility Policy.

I understand that there are risks from telemedicine, including but not limited to: loss of records from failure of electronic equipment; power failure with loss of communication; and invasion of electronic records from outsiders (hackers). In addition, signs and symptoms that might be detected during an in-person physical examination may not be detected through telemedicine.

I understand that I had the option of seeing the physician on a face-to-face basis but opted for a telemedicine appointment due to health and/or commute limitations.

I warrant that the provider/physician observations and recommendations are limited in scope and nature to the specific issues discussed during the telemedicine consult.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

PATIENT INFORMATION

Patient Name:	Date of Birth: MM/DD/YYYY

I understand that by signing this form that I am consenting to receive health care services via telemedicine.

PATIENT / PARENT / LEGAL REPRESENTATIVE:

Name:	Relationship:
Signature:	Today's Date: MM/DD/YYYY