Informed Consent for Telemedicine Services

Patient Name: ____ Social Security #: _________________________

Address: ____

Cell Phone #: ______________________________________ Device for use with telemed visit: ___________________

Employer: ____ Date of Birth: ____________________________

Claim Number: ________________________ Date of Injury: _____________ Location of Patient: ______________

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Ann Delucas, PhD providing psychological services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to you medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit if applicable.

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. I may revoke my consent orally or in writing at any time by contacting the providers office, Claims Examiner or Nurse Case Manager. As long as this consent is in force Ann Delucas, PhD may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient: ______________________________________ *Date*: ____________________

I have been offered a copy of this consent form (patient's initials) ____________