THE
HAND & UPPER EXTREMITY
CENTER OF GEORGIA
ADULT & PEDIATRIC

Specialized Care You Can Trust

Telemedicine Consent Form

In order to reduce possible exposure to coronavirus/COVID-19, our practice is implementing telehealth virtual visits via interactive video conferencing for new and established patients. **This is a temporary measure in response to the COVID-19 crisis.**

Because this is in response to a national health emergency, the service used may not comply with all of the HIPAA Privacy and Security requirements.

1. **Purpose.** The purpose of this form is to obtain your consent to participate in a telehealth service provided by The Hand & Upper Extremity Center of Georgia.

2. **Your Rights.** You may withhold or withdraw your consent to the telehealth service at any time without affecting the right to future care or treatment.

3. **Risks and Benefits.** Please read and sign below that you acknowledge and understand this consent form.

I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the provider.

I understand that delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

I understand that in some instances, security protocols could fail, causing a breach of privacy of personal medical information.

I understand that telehealth is being utilized during the COVID-19 crisis as a way to reduce potential exposure to coronavirus and that face-to-face encounters will be encouraged once the risks associated with the virus have been minimized.

I understand that there are no guarantees with telehealth services, and it should not be used for emergency communications or urgent requests.

I understand that billing information is collected for telehealth visits in the same manner as for in-office visits. My financial responsibility will be determined individually and governed by my insurance carrier(s). It is my responsibility to check with my insurance carrier to determine coverage.

The physician, or other provider, has answered all of my questions.

By electronically signing below, I agree I have received an explanation of how the video and audio technology will be used to conduct the telehealth service, and I understand that there are limitations to the technology and the process of telehealth, including the potential for incomplete exchange or loss of information. I understand and consent to participate in and be videotaped and recorded during the telehealth services. I understand the written information provided above, and I hereby voluntarily and freely agree and give my consent to take part in the telehealth service. I agree to accept responsibility for following my provider's recommendations, including further diagnostic testing or an in-office visit.

X _____

Patient or Guardian