



Telemedicine Consent Form

Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

By signing this form, I certify:

1. I understand that my provider and I wish to engage in a telehealth session. I have had the alternatives to the telehealth session explained to me, and I am choosing to participate in a telehealth session.
2. My provider has explained to me how the HIPAA compliant video conferencing app/program will be used. They have shared with me that such a session will not be the same as a direct client/provider visit because I will not be in the same room as my provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
4. I understand that my provider or I can discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my provider may not have the opportunity to perform an in-person physical examination and may rely on information provided by me. I acknowledge that my provider's advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition, and care that is complete and accurate to the best of my ability.
6. I understand that billing will occur as usual.
7. If CNA Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation.
8. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary.
9. If I experience an urgent matter, such as an adverse reaction to any treatment after a telemedicine session, I should alert my treating provider and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.
10. I understand that the disclosure of my medical information to CNA Telemedicine Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing



unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

11. I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents, including the risks and benefits of telemedicine.

Patient Name: _____

Date of Birth: _____

Signature: _____

Today's Date: _____

In the event the telemedicine session is interrupted due to a technological problem or equipment failure, a provider may use the following contact information to communicate with me:

Phone: _____

Email: _____