Reston Podiatry Associates, LTD

Informed Consent for Telehealth Services

Patient Name: Location of the Patient:	Date of Birth:
Provider Name: Site/Location:	Date Consent Obtained:

Introduction:

Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio and video telecommunication system that permits real-time communication to persons who are at some distance from the provider.

Purpose: The purpose of this telehealth service is to enable patients to receive medical care by a provider.

Privacy and Security: I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

Nature of Telehealth Consultation: I give consent to all doctors affiliated with Reston Podiatry Associates, LTD who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Discuss and monitor examination/procedure/treatment
2. Diagnosis, follow-up and educational purposes
3. Photo recordings may be taken during the encounter
4. Non-medical technical personnel may be present in the telehealth area to aid in video transmission
5. Other _____

Medical Records: I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my consent.

Alternatives: I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. At first, you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact. Following the telehealth consultation, your Provider may recommend an in office visit to for further evaluation.

Rights: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I have had a direct conversation with the above doctor, during which I had the opportunity to ask questions concerning telehealth service. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telehealth consultation.

Date: _____

_____ _____

Signature of Patient Witness

_____ _____

Signature of Authorized Representative Relationship to Patient

_____

Signature of Patient and Provider where Provider has read Consent Form to Patient