STATERA
Integrated Health & Wellness Solutions

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Telemedicine Consent and Release of Liability

Patient Name: _____ Date of Birth:_____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. I understand that video conferencing technology will be used to affect such a consultation and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider, and no physical assessment can be performed.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties, though every effort is made to provide a reliable and highly secure platform. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Staff other than my health care provider may also be present during the consultation in order to operate the technical equipment. These staff members will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence if any and thus will have the right to request the following: (1) omit specific details of my history that are personally sensitive to me; (2) ask non−medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I am choosing to participate in a telemedicine consultation, at my providers recommendation but of my own free will.

6. I understand that billing will occur from my provider and submitted to my insurance or to myself just as if I where seen in the office and it is my responsibility to pay for cost, copay or deductible as may occur.

7. I understand that at anytime during the video consultation if an in person visit is deemed necessary on the same day to continue this appointment I will not be charged for two visits on the same day, however, if a followup visit in person is arranged for a future date, that will be considered a second appointment for billing purposes.

8. By signing this form, I certify: (1)That I have read or had this form read and/or had this form explained to me (2)That I fully understand its contents. (3)That I have been given opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time