

## TELEMEDICINE CONSENT

1. **INTRODUCTION AND PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine health service provided by Baker Family Naturopathic in connection with the following services or procedure(s) provided:

2. **NATURE OF TELEMEDICINE HEALTH SERVICE:** We offer virtual consultations which involve the use of electronic communications to allow us to provide patient care. The virtual provision of our services allows us to use information gathered electronically for diagnosis, therapy and follow-up, and/or education. As with any medical procedure, there are potential risks associated with virtual consultations. We use our best efforts to ensure that your personal and confidential information is kept securely and our electronic systems will incorporate network and software security protocols 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. However, by agreeing to receive our services virtually, you acknowledge and agree that:

- a) In rare cases, information transmitted may not be of sufficient quality to allow for appropriate therapeutic decisions.
- b) Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- c) In rare cases, security protocols could fail, causing your personal information to be accessed by third parties;
- d) We cannot guarantee the availability of virtual consultations which may become unavailable due to system backup procedures, internet traffic volume, upgrades, overload of requests to the servers, general network failures or delays, or any other cause which may from time to time make our virtual services inaccessible to you.

3. **CONSIDERATIONS:** Telehealth does have some considerations:

- a) The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery. The patient agrees that the practitioner determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter.
- b) The practice may, in some cases, be required to forward patient-identifiable information to a third party, for instance upon request by your insurance company. This is not different than the requirements for other non-telehealth medical records.
- c) Additionally, the patient (or guardian) is responsible for determining health insurance benefits for Telehealth visits and is responsible for amounts not paid by insurance.
- d) In the event that my telemedicine session is disrupted or distorted by technical failures, I would like to be contacted via telephone at: \_\_\_\_\_.

4. **PRIVACY AND SECURITY:** All existing laws regarding privacy and security of your health information and copies of your medical records apply to this telemedicine health service and the audio and video information transmitted, received and stored electronically as part of this service. Any dissemination of patient-identifiable images or information from this telemedicine interaction to researchers or other entities for purposes other than your treatment, payment for healthcare services you receive, and certain necessary administrative and operational activities supporting your care shall not occur without your authorization.

5. **DISPUTES:** I agree that any dispute arising from the telemedicine consult will be resolved in Oregon, and that Oregon law shall apply to all disputes.

I understand and agree with the above, and consent to using Telehealth at Baker Family Naturopathic.

\_\_\_\_\_  
Patient (or Guardian) Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Printed Name