Neurology & Sleep Associates

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Informed Consent for Telemedicine Services

Patient Name: _____

Date of Birth: _____ Account No. _____

I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site/location than the provider; and hereby CONSENT to healthcare services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any co-payments, co-insurances and/or deductibles not met that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care any any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my healthcare provider.

As long as this consent is in force, my healthcare provider may deliver healthcare services to me via telemedicine without the need for me to sign another consent form.

Patient Signature: _____ Date: _____
(or person authorized to sign for Patient)

If authorized signer, relationship to Patient: _____