SOUTH FLORIDA ENT ASSOCIATES

BROWARD Sinus & Allergy CENTER

INFORMED CONSENT FOR TELEMEDICINE SERVICES

A telemedicine visit means that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. It involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

• Patient medical records
• Medical images
• Live two-way audio and video
• Output data from medical devices and sound and video files

Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- Your treating provider will be at a different location from you. Additional medical or registration personnel may also be present in the room with the Provider.
- You understand that your voice and image may be recorded in order to assist in your treatment and you consent to any such audio and video recording.
- You understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. You understand there are alternatives and limitations to this type of care. You understand that your health care provider or you can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for your situation.
- You understand that you may be disconnected before all your medical problems are known or treated and it is your responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- You understand that in rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- You understand that standard deductible and coinsurance amounts apply to these Telemedicine visits and you consent to treatment via Telemedicine.

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Notice of Privacy Practices:

Information received or created during delivery of telehealth services is subject to our Notice of Privacy Practices which can be found on our website at sfenta.org
By accepting South Florida ENT Associates invitation to participate in a telemedicine visit via one of the available applications (i.e., Doxy.me, Facetime, Skype etc.), you acknowledge that you understand and agree with the following:
1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted at a facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination 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.
7. I acknowledge receipt of the Notice of Privacy Practices.

Patient Consent to The Use of Telemedicine
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.
I have read this document carefully and understand the risks and benefits of the teleconferencing consultation and have had my questions explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

By accepting South Florida ENT Associates invitation to participate in a telemedicine visit via one of the available applications (i.e., Doxy.me, Facetime, Skype etc.), I hereby authorize my South Florida ENT Associate Provider to use telemedicine in the course of my diagnosis and treatment.