

Advanced Dermatology of Oregon Telemedicine Verbal Consent:

Review the following with the patient and obtain verbal consent and document verbal consent to the following:

Patient Name: _____ DOB: _____ Patient Location: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care professional has explained to me that the visit will be on the phone or video conference and 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.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. In rare cases, information may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the telephone or video 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. Visits are not recorded and the platform our office uses is HIPPA compliant.
5. I have had the alternatives to a telemedicine consultation explained to me, and I have chosen to participate in a telemedicine consultation.
6. In an emergent situation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the telephone or video connection.
7. I understand that billing will occur from my practitioner. Insurances are generally covering services. We cannot guarantee coverage. Patients should check with insurance plan regarding coverage of Telehealth services.
8. I have had the opportunity to ask questions in regard to this procedure. 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.
9. I understand that this consent is valid for one year from today's date unless I specifically rescind my consent for telemedicine appointments.

By verbally consenting to the above, the patient certifies that: he/she has read or had this form read and/or had this form explained to them. And that they fully understand its contents including the risks and benefits of the procedure(s). The patient has been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Health Care Professional that obtained verbal consent from patient:

Name: _____ Signature: _____

Date: _____ Provider Location: _____

Patient email address: _____

Patient phone number (back up): _____