Informed Consent for Telemedicine Services

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE :_____

Email:_____

I understand that telemedicine is the use of electronic information and communication technologies by a Scottsdale Sports Medicine Institute Provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Scottsdale Sports Medicine Institute providing health care 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 copayments or coinsurances that apply to my telemedicine visit. **I understand that I am responsible for any fees that are not reimbursed by insurance.** After hours telemedicine is not billed to insurance and any fees will be due before the online appointment**.**

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. I may revoke my consent orally or in writing at any time by contacting Scottsdale Sports Medicine Institute at (480)664-4615. As long as this consent is in force or has not been revoked, Scottsdale Sports Medicine Institute may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient: _____

If minor, signature of parent or guardian: _____

Date: _____

I have been offered a copy of this consent form (patient's initials) _____.