LOS
LOUISIANA ORTHOPAEDIC SPECIALISTS

Informed Consent for Telemedicine Services

Patient Name:_____ Date of Birth: _____

1. I understand that my healthcare provider wishes me to engage in a telemedicine consultation.
2. My healthcare provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/healthcare 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. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if the videoconferencing connections are not adequate for effective communication.
4. 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 health care provider in order to operate the video equipment. All those individuals involved 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.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date