Rios Family Medicine Clinic
Telemedicine consent form

Informed Consent to Telemedicine/Telepharmacy Consultation

I have been asked by my healthcare provider to take part in a telemedicine/telepharmacy consultation with Rios Family Medicine Clinic and its physician, and others deemed necessary to assist in my medical care through a telemedicine consultation.

I _____, understand the following:

1. The purpose is to assess and treat my medical condition.

2. The telemedicine/telepharmacy consult is done through a two-way video link-up whereby the physician can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. Since the telemedicine consultants' practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. Rios Family Medicine Clinic telemedicine/telepharmacy consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. I can ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.

6. I know there are potential risks with the use of this new technology. These include but are not limited to:

• Interruption of the audio/video link.

• Disconnection of the audio/video link

• A picture that is not clear enough to meet the needs of the consultation

• Electronic tampering.

If any of these risks occur, the procedure might need to be stopped.

7. I may be required to go to the location of the consulting physician if it is felt that the information

obtained via telemedicine was not sufficient to make a diagnosis.

8. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.

9. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan; however, the video images will only be used for those purposes unless further authorized below.

10. I will not receive any royalties or other compensation for taking part in this telemedicine/telepharmacy consult.

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11. I understand I can make a complaint of my provider to the Texas Medical Board by going online at

http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize Rios Family Medicine Clinic and its physician, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

I give my consent to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting health care provider.

I authorize the release of any relevant medical information about me to the consulting health care

provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

I hereby release Rios Family Medicine Clinic, and its personnel and any other person participating in my care from all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in the

telemedicine visits under the conditions described in the document

Date: _____

Signature:_____ Printed Name:_____

Date of Birth:_____

Interpreter (if applicable):_____

Please forward to: frontdesk@riosclinic.com or Fax# 888-809-8549